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This project aims to enhance the capacity of the Air Force (AF) to reduce death, injury, and degraded force readiness via reduction of he prevalence and impact of family maltreatment, suicidality, and alcohol/drug problems. Managing risk and increasing resilience in military human resources (i.e., "Force Health Protection") is a top priority for DoD and Armed Forces leadership. The objective of this study is to enhance the AF's current prevention delivery (known as the Integrated Deliver System; IDS) infrastructure through (a) development and validation of an information system needed to direct prevention efforts more effectively and efficiently; (b) adoption of a prevention-science-based approach; and (c) evaluation of its effectiveness. When funded, the proposed project was broken into two phases. This first phase is a demonstration project on which to build a randomized trial. This project includes: (a) pilot testing the development of an innovative surveillance system and validating its accuracy (at 3AF bases) for family maltreatment, suicidality, and problematic alcohol and drug use, and (b) pilot testing the creation of an enhanced IDS by training community leaders in prevention-science-based intervention methodology and testing the impact on factors that are prerequisites for effective community prevention initiatives and on targeted outcomes.

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Table of Contents

INTRODUCTION: *Narrative that briefly (one paragraph) describes the subject, purpose and scope of the research.*

This project aims to enhance the capacity of the Air Force (AF) to reduce death, injury, and degraded force readiness via reduction of the prevalence and impact of family maltreatment, suicidality, and alcohol/drug problems. Managing risk and increasing resilience in military human resources (i.e., "Force Health Protection") is a top priority for DoD and Armed Forces leadership. The objective of this study is to enhance the AF's current prevention delivery (known as the Integrated Delivery System; IDS) infrastructure through (a) the development and validation of a information system needed to direct prevention efforts more effectively and efficiently; (b) the adoption of a prevention-science-based approach; and (c) the evaluation of its effectiveness. When funded, the proposed project was broken into two phases. This first phase is a demonstration project on which to build a randomized trial. This project is meeting the objectives by: (a) pilot testing the development of an innovative surveillance system and validating its accuracy (at 3 AF bases) for family maltreatment, suicidality, and problematic alcohol and drug use, and (b) pilot testing the creation of an enhanced IDS by training community leaders in prevention-science-based intervention methodology and testing the impact on factors that are prerequisites for effective community prevention initiatives and on targeted outcomes.

BODY: *This section of the report shall describe the research accomplishments associated with each task outlined in the **approved** Statement Of Work. Data presentation shall be comprehensive in providing a complete record of the research findings for the period of the report. Appended publications and/or presentations **may** be substituted for detailed descriptions but **must** be referenced in the body of the report. If applicable, for each task outlined in the Statement of Work, reference appended publications and/or presentations for details of result findings and tables and/or figures. The report shall include negative as well as positive findings. Include problems in accomplishing any of the tasks. Statistical tests of significance shall be applied to all data whenever possible. Figures and graphs referenced in the text may be embedded in the text or appended. Figures and graphs can also be referenced in the text and appended to a publication. Recommended changes or future work to better address the research topic may also be included, although changes to the original Statement of Work **must** be approved by the Grants Officer. This approval must be obtained prior to initiating any change to the original Statement of Work.*

Year 1 (1-12 months)

Task 1: Administer CA+ survey to 4 test sites, implementing strategies to increase response rate (Months 1-3)

Necessary to accomplish:

1. Travel to four pilot bases to conduct orientations; conduct follow-up consultations/trainings as needed
2. Increase response rates via email and postal reminders and telephone-administered surveys

Task 1.1: Base recruitment/orientation

Wing CCs at three ACC bases (Barksdale AFB, Minot AFB, & Shaw AFB) and one AETC bases (Tyndall AFB) were briefed; all volunteered their bases for participation. Permission granted to ask frank, direct questions about secretive problems as a supplement to the 2003 CA at their bases. Minot AFB, (Minot, North Dakota) was originally part of the study but withdrew before survey launch due to the high operations tempo due to Operation Iraqi Freedom.

Task 1.2: Survey Administration

Overview of Design

The AF Community Assessment and the supplemental survey (CA+) were administered via the WWW at three volunteer bases (Barksdale AFB, Shaw AFB, and Tyndall AFB). Approximately 900 randomly selected AD members and 1,100 spouses were invited to participate at each base. At regular intervals they were reminded of the survey by a series of emails (AD members) or postcards (spouses). The survey was active for approximately 11 weeks (May 1 – July 15, 2003). Note that this was a period of high stress and deployments due to Operation Iraqi Freedom. Each base conducted its own publicity and "get out the vote" campaign. The CA contractor and Stony Brook sent out regular reminders by email/mail, an empirically-tested way of boosting response rates (e.g., Dillman, 1999).

Given the considerable variation — especially among spouses — in the ease of internet access and the connection speed available, we offered potential respondents the option of completing the survey anonymously by phone, We called potential participants to determine the additional utility of outgoing calls as (a) a personalized reminder about the survey, especially in messages left on answering machines and (b) a means of increasing response rates by personally offering telephone administration as an alternative to WWW administration..

Based on feedback from focus groups conducted prior to this project, several steps were taken to minimize respondent burden and to increase respondents' confidence in the anonymity of the survey. First, respondents were asked to log in to the survey site and select their own non-identifying and unique user identifications and passwords. Respondents were informed that they could take the survey from any computer with an internet connection. Respondents were able to exit and re-enter the survey from any computer at any time after they had established their IDs and passwords. When respondents began the supplemental portion of the survey, they received a consent page ("Information to Help You Decide If You Want to Participate") which described the sensitive questions they were about to be asked, the rationale for asking them, and a summary of how the data will be used and when and how they will be able to learn the results for their community. The supplemental survey screen had links that provided reminders about anonymity and other information provided earlier.

Sample

Air Force Personnel Center (AFPC; Randolph AFB, TX) drew the AD member and spouse samples[1] and provided Caliber Associates (the CA contractor) with email addresses (for AD members) and postal addresses (for spouses). A random sample of approximately 900 AD members and 1,100 spouses was drawn at each base.

Caliber Associates contacted potential AD respondents via email and administered the survey to them via the WWW. At CA+ bases, Caliber sent spouses a postcard with the CA web addresses and requested their participation. (At non-CA sites, Caliber mailed a paper version of the CA to spouse via postal mail, but gave them the option of completing it by WWW.)

There was no recruitment specifically for the supplement. When individuals at a CA+ base completed the CA, a screen appeared with information about the supplement and, after consenting, continued with the supplement questions.

PT[1] Although members of the Air Force Reserve Command were also sampled separately, they were not part of the CA+ process and therefore we will not discuss them in this report.

Randomly selected AD members (n = 2,695) and spouses (n = 3,214) were invited to participate at three volunteer Air Force Bases: Barksdale AFB (Shreveport, LA), Shaw AFB (Sumter, SC), and Tyndall AFB (Panama City, FL).

The number of participants invited to participate and the number who completed at least part of the CA+ at each base are listed in Table 1. However, an error in the initial sample pull provided to the Caliber contributed to a bias in these figures. AD members married to other AD members were included in the random sample of spouses. When they went to the WWW to complete the survey, they were not asked about whether they were sampled as an AD member or a spouse. Thus AD member "spouses" were counted by Caliber as completing AD member surveys but as receiving spouse invitations. This had the effect of inflating the AD member response rate and deflating the spouse response rate[2]. These rates are adjusted in Table 2. The dual AD marriage rate is 9%. If dual-AD couples represented 9% of spouses, then to account for the above-described problem, AD invitations number should be increased by 9% and the spouse invitations number decreased by 9%. Adjusting the denominator in this way had the effect of reducing the AD member response rate from 63% to 56% and increasing the spouse response rate from 23% to 25%.

Table 1. *Participants in CA+ by base*

	AD Members			Spouses			Total		
Base	*n*	Invitations	Response Rate	*n*	Invitations	Response Rate	*n*	Invitations	Response Rate
Barksdale AFB	685	931	74%	241	1149	21%	926	2080	45%
Shaw AFB	518	920	56%	280	1150	24%	798	2070	39%
Tyndall AFB	484	845	57%	232	1042	22%	716	1887	38%
Total	1687	2696	63%	753	3341	23%	2440	6037	40%

Table 2. *Participants in CA+ by base, adjusted for dual AD spouse misidentification*

	AD Members			Spouses			Total		
Base	*n*	Adjusted Invitations	Adj. Response Rate	*n*	Adjusted Invitations	Adj. Response Rate	*n*	Adjusted Invitations	Adj. Response Rate
Barksdale AFB	685	1034	66%	241	1046	23%	926	2080	45%
Shaw AFB	518	1024	51%	280	1047	27%	798	2070	39%
Tyndall AFB	484	939	52%	232	948	24%	716	1887	38%
Total	1687	2997	56%	753	3040	25%	2440	6037	40%

Measures

Risk and Protective Factors. The CA is a survey of community capacity that includes potential risk and protective factors for secretive problems. The 2003 version of the CA underwent extensive revision to correspond with the theoretical model of community functioning adapted by the AF IDS in 1999. Primary and secondary constructs in the model have been operationalized and measures were selected or adapted, whenever possible, from previously used

[2] Furthermore, AD members married to other AD members could have been selected more than once (i.e., in the AD sample and in the spouse sample). This had an unknown impact on response rates.

and/or published measures. Although full-length scales would result in an inordinately long survey, nearly all constructs are measured with multiple items.

Secretive Problems: *Family Maltreatment.* The development and pilot testing of the measure of family maltreatment is summarized above (and described in more detail in Heyman, Slep, & Casillas, 2001).

Secretive Problems: *Alcohol Problems*. The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item self-report measure of hazardous alcohol consumption developed by the World Health Organization in a six country collaborative project. As part of the development study, it was validated against clinical assessments and scoring criteria were developed to maximize both sensitivity and specificity.

The first two questions ask about the frequency and quantity of alcohol consumption. To limit response burden, if individuals report drinking infrequently *and* limiting consumption to one to two drinks per occasion on the CA+, they will not be asked the additional eight questions that assess symptoms of alcohol abuse and dependence.

Secretive Problems: *Drug Use*. The drug use measure is divided into two sections: prescription drug misuse and illicit drug use. Each section provides participants with an alphabetical checklist of drugs of that type (e.g., amphetamines, barbiturates, Codeine; cocaine, hashish, heroin). For each prescription medication checked, the respondent is asked (a) the frequency of use when s/he did not have a prescription and (b) the frequency of use at a dosage greater than prescribed. For each illicit drug checked, the respondent is asked the frequency of use. Focus groups with AF samples indicated that the questions are clear and unambiguous.

Secretive Problems: *Suicidality*. The Center for Disease Control's (CDC) four item suicidality measure has been used in several nationally representative studies: (a) the bienniel (1991-2001) high school-based National Youth Risk Behavior Survey (N = 13,60 respondents; N = 199 schools; Grubman et al., 2002) and (b) the 1995 National College Health Risk Behavior Survey (N = 4,609; Brener, Hassan, & Barrios, 1999). Although face valid, the measure elicited reports of suicidality: 19% of high school students and 10% of college undergraduates reported seriously considering suicide in the last year. Given the relative youth of the AF population, these findings imply that the measure is adequately sensitive for use in the AF.

Procedures

Preparation for Survey Launch

Survey preparation involved collaboration with contractors, preparation of pilot bases and SB in house preparation for the phone administration.

Collaboration on development of WWW-based supplement

Stony Brook provided Caliber Associates with a mock-up of the supplement and detailed instructions about skip patterns. Caliber's software programmers then developed a test version of the CA and supplement. On 15-Jan-03 Drs. Heyman and Slep traveled to the Vienna, VA offices of Caliber associates and tested the prototype. Together with Caliber Associates' programmers they created an extensive list of needed corrections. Toward the end of the day, Maj. Whitworth joined the meeting via telephone to discuss the progress and next steps.

Stony Brook and Caliber were in frequent contact following that meeting. Caliber conducted some of their own early beta-testing, which is described in their own deliverable products. Stony Brook also began beta-testing both the CA and the supplement, referring

problems and suggestions to Caliber's programmers. With each iteration, Caliber would notify Stony Brook that a revised version of the CA+ was online and ready for testing. Stony Brook would then immediately have 7-20 people extensively test that version. To ensure comprehensive testing, Stony Brook's testers were often each given a "profile" of a respondent-type that they were to use in completing the questionnaire (e.g., married 22-year old E3 with two children). A list of needed changes would be sent within several days, and the process would repeat. Telephone discussions between Stony Brook and Caliber were held frequently to clarify or deliberate bug fixes/requests. Occasionally, Maj. Whitworth joined these teleconferences.

The CA+ took 30-60 minutes for beta testers to complete, depending on which profile they chose to use to enter responses.

Stony Brook Preparation

Stony Brook prepared for the survey launch by adapting Caliber Associates' marketing materials to CA+ bases' specific needs. Marketing materials, suggestions for increasing response rates, and survey information sheets were included in this presentation. Preparation also included training research assistants to administer the survey by phone.

Preparation for survey launch at bases

A video teleconference among teams at the three CA+ bases, Maj. Whitworth, and Drs. Heyman and Slep was held on 26-Feb-03 to prepare the bases for CA+-specific issues (e.g., development and dissemination of CA+ marketing packages, obtaining wing commander's endorsement to be placed into the CA+, helping bases understand what elements of the general CA survey launch marketing materials would and would not apply to them).

A satellite video conference was held on 7 Mar 03 to prepare all AF bases (including the CA+ bases) for the CA. This video conference included overviews about the CA from AFMSA/SGOF chief Col. Wayne Talcott and FAP Research Director Maj. Jim Whitworth, marketing materials for the general CA, suggestions for increasing response rates and information papers to prepare points of contact (POCs) for questions from their base leadership, AD members, and spouses.

Base Point of Contact Preparation

Preparation for marketing included a teleconference with the pilot bases regarding materials specific to the CA+. POCs were also tasked with obtaining respondent phone numbers once the sample was received from AFPC.

Base POCs were kept up to date on the status of the survey instrument through regular phone communication, email, and a listserv. Once the survey was launched, teleconferences were used to share marketing ideas and relay plans for reminder emails and postcards.

Selecting sample and soliciting participation

At the time of funding, the survey was scheduled to launch in early April, 2003; however, it was delayed due to difficulty in obtaining sample information from AFPC (exacerbated by Air Staff's urgent personnel information needs due to Operation Iraqi Freedom).

Active Duty members: First invitation

As noted above, randomly sampled AD members received an email (sent by Caliber Associates), on or about May 1, 2003 from Lt. Gen. Joseph H. Wehrle, Jr. (Assistant Vice Chief of Staff of the Air Force), announcing the 2003 CA, requesting their participation, and providing

a link to complete the CA online. Maj. Whitworth received several emails from AD members questioning the legitimacy of the survey, since both the invitation and the website were not from a known, ".mil" source. AFMSA/SGOF arranged for General Wehrle's letter to be posted on a .mil site that also contained a link to Caliber's CA site.

Active Duty members: Subsequent invitations

Email reminders were sent to AD members on 27-May-03, 16-Jun-03, and 1-Jul-03.

Spouses: First invitation

Randomly sampled spouses at CA+ bases received a letter from Lt. Gen. Wehrle (mailed by Caliber Associates) on or about 1-May-03 announcing the 2003 CA, requesting their participation, and providing a link to complete the CA online.

Spouses: Subsequent invitations

Past CAs used a single invitation to spouses (i.e., no systematic follow-ups to non-respondents were made) and obtained a response rate of approximately 25%. We attempted to improve on this response rate by using a series of postal and telephone reminders (as suggested by Dillman, 2000) and by providing a toll-free number to contact the researchers..

Spouses received a series of postcards encouraging them to participate and offering them the option of completing the survey anonymously by phone with Stony Brook project staff (i.e., instead of using WWW). All postcards had Stony Brook as the return address[3] and included Maj. Whitworth's email address listed as the AF point of contact. All cards had information regarding survey participation, contact numbers and the website address.

The "second request" postcards were mailed by Caliber Associates on 20-May-03. Mistakenly, cards were addressed to the AD member — not to "the spouse of [the AD member]." This caused tremendous confusion and may have resulted in some AD members erroneously completing the CA when they were not in the sample. To minimize this, Stony Brook sent an email to all affected AD members explaining that the invitation was meant for their spouse.

A postcard stamped "third request" was mailed by Stony Brook ten days later (30-May-03).

A "final request" postcard was mailed by Caliber Associates on 3-Jun-03 (to make up for the problematic second request postcard). This postcard reminded spouses that the survey would end on 28-Jun-03. However, after the postcard was mailed, the AF decided to extend the survey deadline to 15-Jul-03 because of the upheaval related to Operation Iraqi Freedom.

Survey Administration

After the initial launch, performance problems with the network server (caused by the initial volume of activity) resulted in slow survey page transitions and, in some cases, computer crashes. After discovering the problem, Caliber was able to adjust its database parameters to more compatible settings, resolving the problems by 5-May-03.

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[3] The number of postcards returned as undeliverable was as follows: Barksdale AFB (n = 129, Shaw AFB n = 158, Tyndall AFB n = 109)).

Help lines

Caliber Associates maintained a telephone helpline for the survey. When dialed, the helpline connected to an automated voice mail system prompting the caller to leave specific information regarding the problem s/he was experiencing with the online survey and information as to how s/he should be reached.

In addition, Stony Brook installed a toll-free telephone line to provide the opportunity for potential respondents to ask questions regarding participation and/or to complete the survey over the phone with our trained staff. This phone was answered by either the project director or a trained staff member six days a week between the hours of 9:00 a.m. and 9:00 p.m. Voice mail messages (received outside of working hours) were returned by either the project director or a staff member. The toll-free number was supposed to be active during the entire data collection period. On 5-Jun-03, one month into the survey, it was discovered that the phone service was not working properly. According to Stony Brook's telecommunications representatives, service was activated only for the northeastern United States, thus making it unavailable to all study participants. On 9-Jun-03 phone service became available to all regions. From that date until the conclusion of the survey on 15-Jul-03, we received approximately 45 incoming calls.

CA Online Administration

The CA was estimated to take approximately 20 minutes to complete, depending on whether the respondent is in a relationship and/or has children. Final figures on how long it actually took participants to complete the CA are not yet available from Caliber Associates; however, it appears that completion time was substantially longer.

Respondents initially created a user name and password which allowed them to re-enter the site at a subsequent time to complete the survey. Respondents were permitted to skip questions without being alerted to the missing responses (i.e., unintentional and intentional skips were treated the same way).

Supplement Online Administration

If the respondent indicated that s/he was at Barksdale AFB, Shaw AFB, or Tyndall AFB, the computer automatically administered the supplement after the CA was completed.

Respondents were required to read a consent document (and click on a button acknowledging that they read it and wished to participate[4]) before answering the supplement questions (due to the research basis for the supplement's inclusion and the sensitivity of the information).

The supplemental survey took between 5 and 30 minutes to complete, depending on the participant's family composition and answers to screening questions (e.g., respondents who did not drink were not asked follow-up alcohol questions). As with the main body of the CA, respondents were permitted to skip questions without being alerted to the missing responses (i.e., unintentional and intentional skips were treated the same way).

After the final supplement question, participants saw one page thanking them for participation and an additional page providing phone numbers for resources available at their bases (e.g., FAP, Life Skills, Alcohol and Drug Abuse Prevention and Treatment [ADAPT]).

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[4] The last line of the consent information page specifically referred to the computer screen. Therefore, for those participating in the telephone survey, this sentence was replaced with, "With your permission, let's begin."

Phone Survey

As noted above, given the wide variability in internet access and connection speed, we offered potential respondents the option of completing the survey by phone. In this option, Stony Brook staff read the questions but entered responses into the same WWW interface that all respondents used. Thus, the interviewer was merely a conduit to typical WWW administration. Oral administration took considerably longer than WWW administration (up to 90 minutes for the CA plus supplement).

Participating Bases

Barksdale AFB chose not to participate in phone calls because they believed that calls, especially those made in a time of war-related deployments, would not be well received. Barksdale did its own recruitment campaign to elicit participation from spouses.

Phone Sample

Stony Brook planned to contact all AD members or spouses in the sample that had not specifically asked to be removed from our contact list (i.e., they had already completed the survey or were choosing not to participate).

AFPC provided names but not phone numbers for the sample. Thus, base POCs were asked to provide phone numbers. Stony Brook was sent a list of approximately 845 active duty and 1,042 spouses for Tyndall AFB, 919 active duty and 1,151 spouses for Shaw AFB, and 931 active duty and 1,021 spouses for Barksdale AFB. A list containing participant name, address, telephone numbers, and base and was kept in a password protected computer file that was accessible only to key personnel. At no time was participant information connected to data.

Unfortunately, the telephone numbers we received for Tyndall's AD sample were very inaccurate. After making fewer than 60 calls, we decided to stop calling Tyndall AFB AD members and to concentrate all of our efforts on Tyndall's spouse and Shaw's AD and spouse samples. Barksdale AFB decided to opt out of the phone calling because of concern over having outsiders calling spouses during a war at such a heavily deployed base. Barksdale increased their own phone calling and other recruitment techniques to make up for this change.

We did, however, make telephone reminder calls to potential participants at Shaw AFB. The results are detailed below.

Delays Encountered

On 30-May-03, 10 days after the "second request" postcard was mailed, Stony Brook began calling the sample as planned. That morning, Tyndall AFB inquired appropriateness of releasing spouse phone numbers because of the Privacy Act. At AFMSA/SGOF's request, Stony Brook suspended calling until the AF/JA's office could offer guidance. Lt. Col. Phil J. Kauffman (Chief, Information and Privacy Administrative Law Procedure, AF/JA) issued a ruling on 27-Jun-03 that the release of spouse phone numbers to Stony Brook was exempt under the Privacy Act and therefore permissible. Calling resumed on 30-Jun-03. Thus, a month of reminder calls/offers to complete the survey by phone was lost.

Procedure

Sampled AD members and spouses were telephoned by Stony Brook up to three times a week with no more than one message left every four days. Those contacted who had not yet completed the survey online were offered the option of completing it by telephone. Due to the

delays noted above, we made calls for twelve days only.

Calling took place over for 69 hours spread over 12 days. Respondents that set up specific appointments were called beyond the 69 designated hours. Outgoing calls were made Monday through Friday from 11:30 a.m. to 8:00 p.m., and Saturday 11:00 a.m. to 3:00 p.m. We successfully completed 45 CAs and 32 CA+s.

Over the 12 day period, each individual received at least two calls. Table 3 below displays the number of overall calls made and their status. Note that the numbers provided are for *calls*, not *individuals*.

Table 3. *Status of Phone Calls Made to AD Members and Spouses*

Status	AD Members	Spouses	Total
Contacted[a]			
Shaw AFB (Columbia, SC)	149	159	308
Tyndall AFB (Panama City, FL)	16	184	200
Total	165	343	508
Message Left[b]			
Shaw AFB	493	302	795
Tyndall AFB	15	392	407
Total	508	694	1202
Incomplete Attempts[c]			
Shaw AFB	352	178	530
Tyndall AFB	14	260	274
Total	366	438	804
Disconnected[d]			
Shaw AFB	111	206	317
Tyndall AFB	23	122	145
Total	134	328	462

Notes. [a]Contact comprises speaking with an individual from the drawn samples and (a) beginning the survey during that call; (b) making an appointment to complete the survey at another time; (c) being told that the s/he was not interested in participating; or (d) being told that the caller the s/he had already completed the survey online. [b]Message left refers to the number of calls during which a message was left, not the number of people for whom a message was left. [c]Incomplete attempts are calls made to an apparently working phone number but no contact was made nor message left. [d]Number was not working, disconnected or no longer in service.

Task 2: Conduct analyses of risk and protective factors on CA+ data (Months 3-5)

Results

As shown in Table 3 below, the annual prevalence of secretive problems was 20.4%. Befitting the "secretive" moniker, only 1 in 6 of members with secretive problems let anyone in the AF (including friends) know. If the prevalences from the CA+ pilot bases were extrapolated to the entire AF, this would mean that 76,075 AD members had serious secretive problems in the last year (10,815 known in some way to the community and 65,260 not known to the community). We should note that AD members in roles requiring more intensive screening (Personnel Reliability Program, flight status, special security clearance) nevertheless reported equivalent prevalences to the overall AD population (e.g., 19.1% reported at least one secretive

problem).

Table 3. *Prevalences of Secretive Problems*

Secretive Problem	Annual Prevalence	Extrapolated AF Estimate
Any secretive problem listed below	20.4%	76,075 AD members
Alcohol problems	8.57%	25,174 AD members
Controlled prescription drug misuse	1.52%	4,465 AD members
Illicit drug use	0.34%	999 AD members
Suicidality	6.22%	18,271 AD members
Partner physical abuse	2.30% (abuse of ♀); 1.70% (abuse of ♂)	5,405 & 3,995 AF couples
Partner emotional abuse	8.94% (abuse of ♀); 8.41% (abuse of ♂)	21,009 & 19,763 AF couples
Child physical abuse	6.87%	8,335 AF families
Child emotional abuse	5.60%	6,810 AF families

➢ *Implications.* We derive the following implications from the 2003 CA+ prevalence results:

- Secretive problems are prevalent in the AF.
- Most members with secretive problems are not identified as such to the AF community.
- Many respondents are willing to report secretive problems on anonymous surveys.

Furthermore, Affirmative responses at these prevalence rates make the planned data analyses feasible and highlight the importance of community-based intervention.

However, there are numerous reasons why respondents might not admit to secretive problems when they do in fact exist. Thus, these rates should be considered the lower estimated bounds of the true prevalences. By trying to reduce community risk/protective factors rather than drive individuals into programs, NORTH STAR has a reasonable chance of impacting even those who are not willing to report secretive problems on a survey.

Risk and protective factor analyses are summarized in Table 4. As can be seen from this table, the CA did indeed include many constructs that are related to multiple secretive problems. In addition to replicating findings in the civilian literature, these results suggest that military-specific variables are significantly related to many of the secretive problems. These risk and protective factor findings are used to guide base IDS teams in prioritizing needs and designing evidence-based action plans (as detailed in the proposal).

Table 4. *Significant relations between risk/protective factors and secretive problems*

					Child Abuse		Partner Physical Abuse		Partner Emo. Abuse	
	Alcohol Problems	Prescr. Drug Misuse	Illicit Drug Use	Suicid-ality	Emo.	Phys.	♂-to-♀	♀-to-♂	♂-to-♀	♀-to-♂
Availability of support from formal agencies			**							***
Availability of social support				*						
Community safety	***	**	***	***			*	**	*	***
Community stressors/problems	*		**	***			***	***	**	***
Community support for youth	*			*			*	***		*
Community unity/responsibility	***		**	***			**	***		***
Depressive symptomatology	***	**	**	***	***	*	***	***	***	***
Financial stress	***		**	**	**		***	***	**	**
Job Stress	*							*	**	

Parenting satisfaction				**	***	*	***	**	***	
Perceived coping ability of spouse/significant other	**	*		***			***	***	***	**
Perceived family coping	*	**	***	***	***	***	***	***	***	***
Perceived personal coping	***	***	***	***	***	*	***	***	***	***
Personal military preparedness	***	**		*						**
Physical well-being	**			**				*	***	***
Relationship satisfaction		**	***	***	**	***	***	***	***	***
Satisfaction with the AF	***	**	***	***			*	***	***	
Spiritual well-being/involvement	***	**		**					**	
Support from leadership	**	*	***	***			***	***		***
Support from neighbors	***			**			**	**		**
Support from significant other		**	***	***			*	***	***	
Work group cohesion		**	***	***				**	*	**

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .001$

Task 3: Implement enhanced IDS, Phase 1

Task 3.1: Travel to the four pilot bases to conduct orientation, training, initiation and pre- / post- testing

Task 3.2: Design and produce training materials. Distribute to four pilot bases and to AFMSA/SGOF

Task 3.3: Conduct pre-, post-, & follow-up assessments of base leadership (Months 2-3, 5, 12)

Task 3.4: Leadership orientation and IDS trainings (Month 4-5)

Task 3.5: Create support system to assist IDSs as proceed through all steps in process (Months 4-12).

Task 3.6: Conduct a resource assessment (i.e., identify current efforts in community) (Months 10-12)

Task 3.1:Travel to the four pilot bases to conduct orientation, training, initiation and pre-/ post- testing *AND*

Task 3.4: Leadership orientation and IDS trainings (Month 4-5)

Bases received their CA+ data and their NORTH STAR on-site training in Oct-Nov 2003. The exact itinerary of each visit was tailored to the individual desires and protocols of the local base, although visits generally consisted of an in-brief to the key leaders and/or the CAIB, 1.5 days of training with the IDS, and an out-brief to the CAIB. The training is encapsulated in the product: *NORTH STAR Training Manual.*

As a result of the training, all three bases have completed the first several steps of NORTH STAR (i.e., prioritizing target problems and risk/protective factors based on their data and identifying possible activities to implement from the Guidebook) and are now in the process of investigating/selecting activities and developing a community action plan. For expository purposes, we will discuss one base's efforts. 2003 CA+ data revealed Shaw AFB's strongest

risk/protective factors to be depressive symptomatology, personal coping, and perceived family coping. These three factors were significant risk/protective factors for alcohol problems, suicidality, spouse emotional abuse, spouse physical abuse, child physical abuse, and child neglect. The IDS then identified three efficacious activities: Triple P (Positive Parenting Program) [effective for all three risk/protective factors], *Feeling Good* book [depression], and the "Stress and the Healthy Mind" course [personal coping, depression].

The IDS scheduled training in Triple P, which targets the knowledge, skills, and confidence of parents through a multi-level family support strategy (i.e., community outreach, brief primary care intervention, intensive family intervention). Training will involve all service providers who routinely interact with families with young children to support a community-wide approach. It also created a dissemination plan for *Feeling Good*, requesting the local TRICARE agency provide most of the funds for the purchase of the books. Process and outcome evaluation is built into the Triple P training. Shaw AFB's IDS has nearly finalized their process and outcome evaluation plan for *Feeling Good*. Similar efforts are underway at the other two participating bases.

Task 3.2: Design and produce training materials. Distribute to four pilot bases and to AFMSA/SGOF

We reviewed the scientific literature for empirically-supported efficacious activities for impacting the 24 risk and protective factors. The resulting guidebook — *Enchancing IDS: A Guidebook to Activities that Work* (included as an appendix) — also included activities that impact risk/protective factors that were not among the 24 included in the CA but which have been empirically demonstrated in the civilian literature. To familiarize IDSs with each activity, a 1-2 page description is provided along with a global "empirical evidence rating" (i.e., "Good," "Better," or "Best"). The activities included in the guidebook represent only a small fraction of those that have been developed to target those risk/protective factors. Strict criteria were used to select interventions for inclusion; that is, all of the activities presented in the guidebook:

- Target research-based risk and/or protective factors for secretive problems. Interventions that *directly* target family maltreatment, substance abuse, or suicidality are not included.
- Are available for implementation. That is, all information and/or materials necessary to carry them out can be obtained from the intervention developer, an independent distributor, a website, and/or other sources.
- Can be practically and feasibly implemented on a community scale.
- Are empirically supported. That is, they have produced significant positive effects on the relevant risk and protective factors in community trials and/or controlled studies.

➢ *Implications.* Empirically-supported, community-level activities could be located for the risk and protective factors in the CA.

Task 3.3: Conduct pre-, post-, & follow-up assessments of base leadership (Months 2-3, 5, 12)

IDS members were assessed prior to and following receiving the NORTH STAR training. Participants were pleased with the NORTH STAR approach to prevention ($M = 4.38$ [out of 5], $SD = 0.57$), NORTH STAR training ($M = 4.56$, $SD = .51$), and NORTH STAR materials ($M = 4.44$, $SD = .65$). Participants' ratings of their estimations of their ability to use CA data to create a community action plan improved significantly after receiving their NORTH STAR training *t*

(49) = 2.57, $p < .05$), as did their beliefs that their efforts would be effective t (49) = 3.63, $p <$ .001.

- *Implications.* We derived four implications from these results. First, survey results revealed an even more pressing need for community-based prevention than had been anticipated. Second, the NORTH STAR approach is understandable and appealing to IDS members and base leadership. Third, the materials that have been developed support the implementation of NORTH STAR as it was designed. Finally, NORTH STAR appears effective in facilitating bases, identifying key needs, and implementing community-wide evidence-based activities to address those needs.

Task 3.5:Create support system to assist IDSs as proceed through all steps in process (Months 4-12).

The following activities have been conducted in support of this aim:

1. We have established bi-weekly teleconferences with base points-of-contact to discuss progress and identify difficulties. This has been very useful in maintaining momentum and in facilitating problem solving.
2. A NORTH STAR website was created to serve as the central repository for information.
3. A listserv was set up to facilitate inter-base communication.
4. The first inter-base teleconference has been scheduled.

Task 3.6: Conduct a resource assessment (i.e., identify current efforts in community) (Months 10-12)

This activity has begun yet. Because the administration of the CA was delayed until May, 2003, project timelines have been pushed back accordingly. The resource assessment will be conducted this summer, after bases have had the opportunity to begin enacting their action plans.

Summary

In conclusion, we are quite encouraged about the progress made in the first 12 months. With NORTH STAR providing the bridge between informational and the institutional infrastructures, the pilot bases appear to have the necessary prerequisites to implement effectively a modern prevention initiative. Base IDS teams were very receptive to the NORTH STAR approach and are making good progress in designing and implementing empirically-supported action plans. The goals set out by PRMRP reviewers for the first phase of the project are being achieved. The next steps are (a) to validate the surveillance system AF-wide and (b) to test the effectiveness of the NORTH STAR approach in enhancing the impact of base IDSs. These are the objectives of the proposed research activities.

KEY RESEARCH ACCOMPLISHMENTS: Bulleted list of key research accomplishments emanating from this research.

- Successfully conducted anonymous survey of family maltreatment, alcohol and drug problems, and suicidality.
- Developed and produced all Enhanced IDS materials to implement evidence-based community prevention approach at test bases.

- Successfully completed training at test bases.

REPORTABLE OUTCOMES: Provide a list of reportable outcomes that have resulted from this research to include: manuscripts, abstracts, presentations; patents and licenses applied for and/or issued; degrees obtained that are supported by this award; development of cell lines, tissue or serum repositories; infomatics such as databases and animal models, etc.; funding applied for based on work supported by this award; employment or research opportunities applied for and/or received based on experience/training supported by this award.

We are too early (less than a year) in the project to have produced papers. Presentations of survey results have been limited to Air Force research meetings. The Guidebook and Training Manual have been included, and the website has been established.

CONCLUSIONS: Summarize the results to include the Importance and/or implications of the completed research and when necessary, recommend changes on future work to better address the problem. A "so what section" which evaluates the knowledge as a scientific or medical product shall also be included in the conclusion of the report.

Our early results highlight the feasibility of implementing the innovative public health surveillance system we proposed and strongly support the importance of better monitoring of otherwise unidentified family maltreatment, alcohol and drug problems, and suicidality. The anonymous survey, despite some technical glitches, was extremely successful. Response rates were good, information appears reliable and valid, and the survey itself was well-received – not a single complaint about the supplement was received by the Air Force, the CA contractor, or the Stony Brook research team. Results indicated that more than 20%, or one in five, active duty members experienced at least one of the secretive problems assessed in the last year. Of those, more than 90% of the affected individuals had succeeded in keeping the problems secret, reporting that no one in the AF has any knowledge of the problem or related issues. Rates of problems were comparable for active duty members with special clearances. Thus, serious levels of family maltreatment, suicidality, and alcohol/drug problems are going undetected and untreated for a sizable minority of AF members, even those with sensitive missions.

Fortunately, our initial results also suggest that our proposed evidence-based approach to community prevention is a good fit to the AF's IDS structure. All participating bases have been successfully trained. Anecdotally, IDS members were very receptive to the training and materials, and expressed great enthusiasm about the approach. Base leadership also appeared committed to reducing secretive problems and very supportive of the proposed approach. Comparisons of pre- and post-training assessments of IDS members and leadership revealed significant improvement in respondents' beliefs that they could construct a strong community action plan and their beliefs that their efforts would be successful. We are encouraged that, with ongoing support (as detailed in the proposal), evidence-based community action plans will be implemented at participating bases and that these efforts will result in reductions in secretive problems. In sum, the results to date support the viability of the proposed approach.

REFERENCES: List all references pertinent to the report using a standard journal format (i.e. format used in *Science, Military Medicine*, etc.).

Not applicable.

APPENDICES: Attach all appendices that contain information that supplements, clarifies or supports the text. Examples include original copies of journal articles, reprints of manuscripts and abstracts, a curriculum vitae, patent applications, study questionnaires, and surveys, etc.

Enhancing IDS: A Guidebook to Activities That Work

Part of the NORTH STAR Initiative

From the Family Translational Research Group at the
State University of New York at Stony Brook

STONY BROOK
STATE UNIVERSITY OF NEW YORK

Enhancing the Integrated Delivery System (IDS): A Guidebook to Activities That Work

Development Information

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Restricted Usage

Because NORTH STAR is being tested, this guidebook may only be used at Barksdale AFB, Shaw AFB, and Tyndall AFB. It may not be shared outside those bases without the explicit approval of the AFMOA/SGZF Research Director (Brooks AFB; comm: 210-536-6808) and the Stony Brook research team.

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Introduction to Enhancing IDS: A Guidebook to Activities That Work

Enhancing IDS: A Guidebook to Activities That Work is designed to help USAF IDSs (Integrated Delivery Services Teams) select effective activities and interventions to be included in their action plans as part of the NORTH STAR Initiative. The NORTH STAR system allows each IDS to choose which targets and interventions to focus on, based on data from the most recent CA and as the resources that are available to the IDS. Such flexibility, pioneered by Hawkins, Catalano and colleagues in their "Communities That Care" program for youth problems, has resulted in excellent community acceptability and promising prevention outcomes.

What are "Activities that Work?"

The guidebook presents interventions and activities that have been shown to reduce known risk factors and increase protective factors for the "secretive problems" of family maltreatment, substance abuse, and/or suicidality. The activities included here represent only a small fraction of those that have been developed for these purposes. Strict criteria were used to select interventions for inclusion. All of the activities presented in the guidebook:

- Target research-based *risk* and/or *protective* factors for the above-mentioned secretive problems. Interventions that directly target family maltreatment, substance abuse, or suicidality are not included.

- Are available for implementation. That is, all information and/or materials necessary to carry them out can be obtained from the intervention developer, an independent distributor, a website, and/or other sources.

- Can be practically and feasibly implemented on a community scale. For example, interventions involving individual psychotherapy are not included in the guidebook. Although psychotherapy has been shown to have many potentially beneficial effects, it is time- and resource-intensive. On the other hand, group workshops are much more cost-effective than individual therapy and are included if they meet the other criteria.

- Are empirically supported. That is, they have produced significant positive effects on the relevant risk and protective factors in community trials and/or controlled studies.

The criterion of empirical support is especially important. Many available interventions have never been evaluated. Most of these interventions "make sense," and quite a few are being widely implemented. The people and organizations that are engaging in such activities often believe that the interventions are effective, but there is no evidence that they work. In contrast, every intervention included in this guidebook has been tested and proven to work.

Of course, the fact that a particular intervention has empirical support does *not* mean that it is perfect. No activity has ever been shown to work for all people, families, organizations, or communities under all circumstances. For example, most of the activities presented here have

been validated only with civilians. It may be that AF communities, AD members, or AF families differ from their civilian counterparts in ways that make an activity less effective or even prevent it from having any beneficial effects at all. On the other hand, it may also be that factors within a military population are likely to *increase* the effectiveness of a given intervention. In any case, even within the same population (e.g., on a given AF base), not everyone will benefit to the same degree—or at all—from any given activity. The activities in this guidebook may not be perfect, but they have been evaluated and have evidence that they can be effective.

Indeed, we have attempted to include the *best available* interventions and activities for each target. Wherever well-validated interventions are available, we have not included other activities that may target the same risk or protective factors, but for which the evidence is not as strong. There are also many activities and interventions that may well be effective, but have not yet been evaluated; these are also not presented here—at least, not yet. This guidebook is intended to be a living document. As new interventions and activities are developed and validated, and as new evidence becomes available for existing interventions, the online version of the guidebook will be updated. All members of the NORTH STAR listserv will be notified whenever these online guidebook updates are posted. Be sure to check the website often for the latest empirically-supported innovations!

How is the guidebook organized?

The effective activities have been grouped according to the level at which intervention takes place. These levels of intervention are presented in order of increasing specificity: 1) Community, 2) Organization, 3) Family, and 4) Individual. Each level is further subdivided according to the relevant risk and protective factors. For example, if you turn to page 31, you will see that the potential target of "Marital/Romantic Relationships" is listed under the Family level of intervention. Within each target, the guidebook is structured as follows:

Introduction

The introduction to a potential target contains a brief discussion of what makes this target an important risk/protective factor.

Items in 2003 AF Community Assessment	Item #s
1. Items in the CA that assess this target are listed here. 2. Chapters on targets that are not assessed by the current CA do not contain this section.	For example: L1, N9, N10, L2

Activities/Interventions

This is simply a list of the interventions and activities that are known to affect the target. It should be noted that many activities are known to influence more than one target. Interventions are listed under each target that they affect; however, a full description of the activity is given only in the chapter on the primary target.

Descriptions of these interventions then follow. For example, if you turn to page 36, you will see the listing for *Couples Coping Enhancement Training (CCET)*, an intervention primarily targeting Marital/Romantic Relationships. The listing for each activity is structured as follows:

Intervention Targets

COMMUNITY ORGANIZATION FAMILY INDIVIDUAL

A given intervention may have many different effects. This section lists all of the NORTH STAR targets that the intervention is known to influence. The primary target is listed first, and it is in the chapter for this primary target that the full intervention description can be found.

DESCRIPTION

This section contains a brief summary of the intervention. Here we discuss what activities are involved and what the intervention was designed to accomplish.

MINIMAL IMPLEMENTATION

This section details who should do what, how often, for how long, if the intervention is to be counted as part of the NORTH STAR Initiative. It may be that a less intense version of a given activity could be effective; however, each intervention has only been validated under conditions of at least the intensity and duration described here.

DOCUMENTED RESULTS (Empirical Evidence: **Rating**)

This section briefly describes the empirical evidence for the effectiveness of the intervention. Specific studies and results are discussed. In addition, we have given each intervention a global Empirical Evidence rating (i.e., **Good**, **Better**, or **Best**). These ratings are our interpretation of the overall quality of the evidence showing that each intervention works, and may help you to decide which activities to implement. The criteria used for these ratings are as follows:

Best

These interventions have been very well validated. Most have existed for many years and have been tested in multiple studies with large sample sizes and control groups. Usually, their effects are known to last for an extended period of time. If an intervention is new, it can receive a rating of **Best** if it (a) is particularly innovative, (b) has been evaluated in at least one well-designed study, and (c) has produced especially impressive results (e.g., *Cognitive Appraisal Program,* page 47). These interventions truly are the "cream of the crop."

Better

These interventions have fairly strong evidence for their effectiveness, but have not been as well validated as the **Best** activities. Often, these interventions are relatively new and thus have not been evaluated in as many studies. The research may have involved a large sample size but no control group, or a control group but a small sample size. Also, long-term follow-up data may not yet be available.

Good

These interventions are promising, and there is at least some evidence that they work. Studies of the effectiveness of these interventions may have involved a small sample size and no control group. If long-term follow-up data is available, it shows that the effects of these activities may not last as long as those labeled **Better** or **Best**. An intervention will also receive a rating of **Good** if only some of the studies evaluating it have found that it works, or if it only works with certain people or under particular circumstances.

RESOURCES REQUIRED

This section indicates the physical, financial, and human resources that would be necessary in order to implement the intervention as described. Specific cost information is included whenever such is available.

This section provides contact information for the intervention developers, distributors, and/or sources of necessary materials. Other sources of helpful, relevant information may also be provided.

References

This section contains citations for the books and articles that have been cited in the chapter introduction and intervention descriptions. These are provided so that anyone interested in additional information (e.g., on the actual validation studies) can refer to the original source.

Charts

Starting on page 104, you will find two charts that may be useful when navigating the guidebook. Chart 1 lists all of the activities described in the guidebook, organized according to the quality of the empirical evidence that supports each intervention (**Best**, **Better**, or **Good**). Chart 2 indicates which targets are affected by each activity, and which interventions can be implemented to influence a given risk or protective factor.

Bibliography

The bibliography is an alphabetical list of all references cited in the guidebook.

Community

Introduction

Communities are defined by more than geographical boundaries. More importantly, they are identified by the interactions among their inhabitants and the connections among people formed through common goals or beliefs. When someone refers to a "good community," they most likely mean a place whose residents feel safe from crime and violence; trust, respect, and support one another; and share responsibility for the quality of the community. Such community bonds have many benefits — both for communities themselves and for the individuals and families who live there (for reviews, see Chavis & Newbrough, 1986; Putnam, 2000). Strong communities are able to solve problems more quickly and more easily and tend to have less crime. Children who live in tight-knit communities are healthier, watch less TV, and do better in school. People in close communities tend to be more successful occupationally, have better physical health, and report being generally happier than in communities marked by social distance and mistrust.

It would seem, then, that strong communities should be an important ingredient in the recipe for us and our society to become "healthy, wealthy, and wise." Unfortunately, as Harvard political scientist Dr. Robert Putnam (2000) has documented, the last four decades have brought what Putnam calls "the collapse of American community." Americans today are less politically active than we have ever been in the past — fewer of us vote than in almost any other Western democracy. Membership and participation growth in many civic groups, religious institutions, professional organizations, and leisure-time associations (such as bowling leagues) has stalled or, in many cases, drastically declined. We are giving less money to charity and volunteering less time for good causes. We spend less time with friends and are increasingly unlikely to know our neighbors. Not surprisingly, Americans today tend to believe that their neighbors are less honest and trustworthy than their parents or grandparents did. Connecting with the community, particularly the off-base community, may be especially challenging for highly mobile AF families, as one of the strongest predictors of a psychological sense of community is the number of years that one expects to live in the community (Glynn, 1986).

In sum, the benefits of belonging to a strong, tight-knit community can be tremendous, but Americans' sense of community is weakening. In response to this decline, hundreds of interventions have been developed to bolster American communities; unfortunately, very few have ever been empirically evaluated. The interventions presented in this section are exceptions to the rule — their ability to effectively accomplish their stated goal(s) has been scientifically tested and validated.

Items in 2003 AF Community Assessment	Item #s
1. Safety from crime and violence	L1, N9, N10, L2
2. Community unity/sense of shared responsibility for quality of community	C10, E1, Q1, Q2, Q3
3. Satisfaction with community	E2, K1, K3
4. Neighbors are friendly and supportive	S1, S2, S3, S4

Activities/Interventions
Community Gardens
Neighborhood Watch/Working it Out
Improved Street Lighting

Community Gardens

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Unity ★ Support from Neighbors			★ Healthy Diet ★ Perceived Personal Coping

DESCRIPTION

A community garden is nothing more than a plot of land where members of a community raise plants — primarily vegetables — in individual or communal plots. Community gardens are becoming more and more widespread; in 1991, it was estimated that one million U.S. households were annually involved in community gardening (Blair, Giesecke, & Sherman, 1991).

MINIMAL IMPLEMENTATION

At a minimum, it is necessary to provide land, prepare the soil, and invite/encourage members and their families to plant gardens on it. An organization to manage the garden (e.g., decides who gets to plant where, etc.) should also be set up for effective implementation.

Due to relatively frequent PCSing inherent to military life, it may be beneficial to provide tools and a tool storage facility rather than asking gardeners to provide their own. Gardening information, advice, classes, and/or workshops might also be provided. It is recommended that bases wishing to start community gardens use and teach a gardening system like "Square Foot Gardening" (see Where to Find More Information below), which provides maximum harvest and enjoyment but requires minimal space, tools, and work.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Researchers have found that community gardening can provide many benefits. For example, since 1977, the Penn State Urban Gardening Program has provided the technical assistance and educational support necessary to help turn over 500 vacant lots in Philadelphia into community gardens. A study (Blair, Giesecke, & Sherman, 1991) compared 144 gardeners from garden sites around the city with 67 controls who lived near the sites but did not garden. Compared to the non-gardeners, gardeners:

- Expressed significantly higher life satisfaction.
- Were more likely to participate in food distribution projects, neighborhood cleanups or beautification projects, and neighborhood barbecues and social events.
- Were more likely to view their neighbors as friendly.

- Consumed 6 out of 14 vegetable categories significantly *more* frequently, while consuming milk products, citrus fruits and juices, sweet foods (i.e., desserts and sweet snacks), and sweet drinks (e.g., soda) *less* frequently.

RESOURCES REQUIRED

The most important necessary resource is plot of land that receives as much daylight as possible during the local growing season. Also, one or more responsible individuals must be able and willing to organize and oversee this relatively long-term activity. Seeds for community garden projects are available free of charge from the America the Beautiful Fund (see below). Tools and storage facilities (e.g., sheds) range in price.

It may also be beneficial to form alliances with local "Master Gardeners" — people who have agreed to volunteer their time teaching others how to garden. They are almost always more than happy to provide advice, information, classes, and/or workshops free of charge. To find Master Gardeners in your vicinity, contact your state Cooperative Extension Office.

WHERE TO FIND MORE INFORMATION

Information on how to create a successful community garden:

American Community Garden Association
1916 Sussex Road
Blacksburg, VA 24060
Tel: (540) 552-5550
Fax: (540) 961-1463
Email: jthies@managementconsultantscorp.com?subject=ACGA
URL: www.communitygarden.org

Free seed information:

America the Beautiful Fund
1730 K St., NW, Suite 1002
Washington, DC 20006
URL: www.america-the-beautiful.org

Information on Square Foot Gardening:

The Square Foot Gardening Foundation
P.O. Box 10
Eden, UT 84310
TOLL-FREE: (877) 828-1188
Email: info@squarefootgardening.com
URL: www.squarefootgardening.com

Neighborhood Watch/ Working it Out

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Safety ★ Community Unity ★ Community Satisfaction			

DESCRIPTION

It goes by various names — Neighborhood Watch, Block Watch, Crime Watch, Window Watch, Town Watch — but whatever it is called, this type of community-based social initiative is becoming increasingly popular. The objectives: reduce crime, fight social isolation, and promote a sense of joint responsibility for the community. The National Crime Prevention Council (NCPC; 2002) states that a Neighborhood Watch is "one of the most effective and least costly ways to prevent crime and reduce fear" (p. 1).

A typical Watch group organizes neighbors to look out for each others' families and property, report any suspicious activities or crimes in progress, and work together to make their community a better place to live (NCPC, n.d.). "Working it Out" takes the Neighborhood Watch a step further; in this intervention, neighbors sign up in groups of 4 or 5 to walk the streets of their neighborhood during peak crime hours. As in all Watch activities, members are not to confront people engaged in suspicious or criminal activity, rather merely to observe and report.

MINIMAL IMPLEMENTATION

Members and their families should be encouraged to sponsor Watch groups or join pre-existing groups in their neighborhoods. For example, a base representative may be assigned to provide newly-arrived member families with information on existing groups in their communities. In addition, good relationships should be fostered between Watch groups and security forces or municipal law enforcement officials.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

The Neighborhood Watch concept is highly respected and widely implemented, and police departments around the country subjectively report significant reductions in crime and fear as a result of Watch interventions (NCPC, n.d.). Unfortunately, however, empirical evidence of their effectiveness is limited. In one study of the "Working it Out" version of Neighborhood Watch (Levine, 1986), two communities in Cambridge Massachusetts began Watch interventions — complete with "walking patrols" — after their areas experienced a sudden crime wave. The following findings were reported:

- The crime wave was halted within a year. The average number of housebreaks per month was reduced by almost 75% (from 54/month to 15/month) and remained at or below the reduced level over four years of follow-up.
- The police department consistently attributed a major portion of the reduction in crime to the Watch program.
- "Walking crimewatchers" reported feeling substantially more secure in their homes and in the community.
- Participants also reported an enhanced sense of community, as well as higher satisfaction with and confidence in the future of the community.

These results must be viewed with some caution, as no comparisons were made to other communities or individuals who did not implement or participate in the intervention.

RESOURCES REQUIRED

Information and suggestions regarding how to set up initiate new Watch groups are available from the groups listed below. Information on already-existing groups will of course have to be collected locally. Other than information and the means of distributing it, no other resources are necessary.

WHERE TO FIND MORE INFORMATION

National Crime Prevention Council
1000 Connecticut Avenue, NW
13th Floor
Washington, DC 20036
Tel: (202) 466-6272
Fax: (202) 296-1356
URL: www.ncpc.org

National Association of Town Watch
P.O. Box 303
Wynnewood, PA 19096
TOLL-FREE: (800) NITE-OUT
Email: info@natw.org
URL: www.nationaltownwatch.org

Improved Street Lighting

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Safety			

DESCRIPTION

In addition to social initiatives like the Neighborhood Watch program, modifications in the physical environment can affect perceived and/or actual safety (see Casteel & Peek-Asa, 2000). The goals of an Improved Street Lighting program, for example, are twofold: to reduce crime itself, and to reduce the fear of crime and the avoidance behaviors (e.g., staying indoors at night) associated with such fears (Herbert & Davidson, 1994). Although it is not yet clear whether brighter streets actually reduce crime, people do seem to *feel* safer if their street is brightly lit (see below).

MINIMAL IMPLEMENTATION

In some areas, implementation may involve something as simple as using brighter bulbs, while in others, it may require wholesale replacement of current lighting fixtures. In any case, lighting along residential streets and sidewalks should be improved so that (a) the light is well-distributed (i.e., minimal "dark pockets"), and (b) a minimum illuminance level of between 1 and 2.5 lux is achieved, as measured by a photometer. (One lux is the brightness of a lit candle one meter away in a dark room, or the light of a full moon; 2.5 lux is brighter than the interior of many fashionable bars and restaurants; Kripke, n.d.).

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

In one study conducted in England (Herbert & Davidson, 1994), people who lived on 5 streets in each of two cities were surveyed both shortly before and within a few months after the lighting on their streets was improved as described above. The results of the post-improvement survey generally showed reductions in participants' (a) fears of falling victim to a crime and (b) perceptions that many kinds of crime (e.g., robbery, vandalism) were big problems in their areas. People — especially women and the elderly — reported being much less afraid to go out after dark, and sharp increases in the numbers of women and older adults on the streets after 9:00 p.m. were observed. Interestingly, men's perceptions of the risks faced by women were decreased even more than the perceptions of the women themselves.

Unfortunately, the time spanned by the study was too short to tell whether improving the residential street lighting had any impact on actual crime in the area. It should also be noted that brighter streets appeared to lead to *increased* perceptions of certain problems, including dog noises and mess, broken paving, and drunken behavior. The authors of the study attributed this to "a combination of visibility and exposure. More residents [were] on the streets at night and the better street lighting [made] them more aware of the problem[s]" (p. 345).

RESOURCES REQUIRED

Specific resources will depend entirely on the size of the area(s) to be improved and the current state of lighting on the streets. It may be necessary to form partnerships with and/or secure grants or donations from local/state governments, businesses, and/or nonprofit organizations.

WHERE TO FIND MORE INFORMATION

National Crime Prevention Council
1000 Connecticut Avenue, NW
13th Floor
Washington, DC 20036
Tel: (202) 466-6272
Fax: (202) 296-1356
URL: www.ncpc.org

Community References

Introduction

Chavis, D. M., & Newbrough, J. R. (1986). The meaning of "community" in community psychology. *Journal of Community Psychology, 14,* 335-340.

Glynn, T. J. (1986). Neighborhood and sense of community. *Journal of Community Psychology, 14,* 341-352.

Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community.* New York: Simon and Schuster.

Community Gardens

Blair, D., Giesecke, C. C., & Sherman, S. (1991). A dietary, social and economic evaluation of the Philadelphia Urban Gardening Project. *Journal of Nutrition Education, 23,* 161-167.

Neighborhood Watch/ Working It Out

Levine, M. D. (1986). Working it out: A community re-creation approach to crime prevention. *Journal of Community Psychology, 14,* 378-390.

National Crime Prevention Council. (n.d.). *Neighborhood watch organizer's guide.* Retrieved September 15, 2003, from http://www.ncpc.org/cms/cms-upload/ncpc/files/orgz.pdf

National Crime Prevention Council. (2002). *Joining a Neighborhood Watch.* Retrieved September 15, 2003, from http://www.ncpc.org/cms/cms-upload/ncpc/files/nwjoin.pdf

Improved Street Lighting

Casteel, C., & Peek-Asa, C. (2000). Effectiveness of crime prevention through environmental design (CPTED) in reducing robberies. *American Journal of Preventive Medicine, 18,* 99-115.

Herbert, D., & Davidson, N. (1994). Modifying the built environment: The impact of improved street lighting. *Geoforum. 25,* 339-350.

Kripke, D. M. (n.d.). *Brighten your life.* Retrieved September 13, 2003, from http://www.brightenyourlife.info/

Organizational Factors

Introduction

In recent years, researchers and human resource professionals have increasingly begun turning their attentions to the problem of work-related stress. What they have found is striking. In a summary of the civilian job stress research literature, Sauter et al. (1999, pp. 4-5) cited the following findings:

- Between 25% and 40% of workers report high levels of work-related stress.
- One-fourth of employees view their jobs as the number one stressor in their lives.
- Three-fourths of employees believe the worker has more on-the-job stress than a generation ago.
- Problems at work are more strongly associated with health complaints than are any other life stressor — more so than even financial problems or family problems.

Indeed, work-related stress has been linked to a wide variety of indicators of ill health and decreased well-being, including headache, sleep disturbances, difficulty concentrating, short temper, disturbed relationships with family and friends, upset stomach, cardiovascular disease, back and upper-extremity musculoskeletal disorders, and various mental health problems, such as depression (European Commission, 1997; Sauter, Murphy, & Hurrell, 1990; Sauter et al., 1999). Job performance can also be affected, as elevated levels of stress may impair an employee's ability to attend to finite details (Fujigaki, 1993) and/or to make creative decisions based on all the necessary and relevant information (Isen, Daubman, & Nowicki, 1987). Stress in the workplace can affect not only the well-being of employees, but that of the organization itself, due to increased rates of absenteeism, decreased efficiency, and increased costs (Murphy, 1996; Sauter, Murphy, et al 1999). For example, health care expenditures are almost 50% higher for workers who report high levels of stress (Goetzel et al., 1998).

Reductions in work-related stress can be achieved in several ways. The proven approaches described below range from simple and specific (i.e., *Personal Stereo Use*) to broad and complex (i.e., *Stress. . .at Work*).

Items in 2003 AF Community Assessment	Item #s
1. Exposure to stressful work schedule/conditions	D1, D2, D3
2. Ability to manage work demands	H1e, M4b-c

Activities/Interventions
Personal Stereo Use
Stress. . .at Work

Personal Stereo Use

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress ★ Satisfactions With Employing Organization		

DESCRIPTION

It has long been documented that listening to music while working can potentially have positive effects on employees' mood states and performance (e.g., Wyatt & Langdon, 1937). However, the results are mixed — that is, not everyone works better to music. The development of personal-stereo headsets (e.g., Sony's Walkman) made it possible to enhance the work environment of those employees who prefer working to music without annoying or distracting those who do not. The design of this activity is simple: Allow personal stereos to be used in the workplace.

MINIMAL IMPLEMENTATION

The intervention works by allowing employees to listen to music if they wish, for as long as they wish, and to whatever style of music they wish. This can be accomplished by permitting or encouraging employees to bring in their own personal stereos and music, or by setting up a music library and providing both headsets and cassette tapes or CDs. Employees should of course be encouraged to exercise discretion in listening (e.g., they should not listen when doing so might be dangerous or make it impossible to do their jobs properly).

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

In 1995, Oldham and colleagues conducted a study of personal stereo use in the business office of a large retail organization. Half of those employees who indicated that, if permitted, they would use a personal stereo at work were allowed to do so for four weeks; the rest were not. Compared to (a) the employees who did not want to listen to music while working, (b) those who wanted to do so but were not permitted, and (c) themselves before and after the four-week allowed listening period, on-the-job personal-stereo listeners demonstrated the following results:

- More relaxed;
- Less nervous;
- More enthusiastic;
- Less fatigued;
- Less distracted by their work environments;
- Better able to concentrate on their jobs;
- More satisfied with the employing organization;
- Less intention to leave their current job in the near future;
- Higher supervisor-rated job performance.

Oldham et al. (1995) found further that the best explanation for the increases in job-performance and organizational satisfaction was the improved ability of personal-stereo users to relax while working. The effects were greatest for employees in relatively simple jobs; in fact, listening was more hindrance than help for employees with extremely complex jobs.

RESOURCES REQUIRED

Other than employee participation, practically no resources are needed for this intervention to be successful.

WHERE TO FIND MORE INFORMATION

N/A

Stress. . .at Work

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress		

DESCRIPTION

The National Institute for Occupational Safety and Health (NIOSH) is the federal agency responsible for conducting research and making recommendations for the prevention of civilian work-related illness and injury, including work-related stress. NIOSH has recently published a booklet, entitled *Stress. . .at Work* (Sauter et al., 1999), which contains not a intervention per se but rather a set of empirically-guided recommendations for designing and implementing a job-stress-reducing intervention tailored to the needs of a given organization. Of course, these recommendations may or may not be applicable within a military context or to certain occupations.

There is evidence that the effects of workplace stress management interventions — which typically educate employees about stress without considering the environment within which they work — often decreases stress only for the short term. Thus, NIOSH recommends that organizations work not only to enable individual employees to cope better with work-related stress, but also — and perhaps more importantly — to make fundamental stress-reducing and/or -preventing changes in work conditions, policies, and procedures. For example, possible ways to change the organization to prevent job stress include:

- Ensuring that the workload is matched to employees' capabilities and resources
- Clearly defining employees' roles and responsibilities
- Improving communications — reducing uncertainty about career development and future employment prospects
- Providing opportunities for social interaction among employees
- Establishing reasonable work schedules that are compatible with outside demands and responsibilities (e.g., family)

MINIMAL IMPLEMENTATION

While the NIOSH authors (Sauter et al., 1999) make no specific, universal prescriptions for job stress prevention, the process for any organization will include identifying potential problems, designing and implementing an intervention, and evaluating the intervention's success. In order for this process to succeed, preparations must include:

- Making employees and the organization more aware of the nature of stress and its risk factors and consequences
- Committing top organizational authorities to support the intervention

- Incorporating employee feedback and involvement in all phases of the process (i.e., problem identification, intervention design, implementation, and evaluation)
- Establishing the technical capacity to conduct the intervention (e.g., specialized training for base staff or use of job stress consultants)

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

The NIOSH recommendations for decreasing job stress are based on the accumulated results of a wide array of research studies. Unfortunately, there is as yet no direct evidence that following their guidelines specifically alleviates stress for the individual within the workplace. However, there is some very good indirect evidence for the effectiveness of this type of intervention. For example, the St. Paul Fire and Marine Insurance Company conducted multiple studies of stress prevention activities in hospital settings (Jones et al., 1988). Intervention elements included (a) employee and management education regarding job stress, (b) changes in hospital policies and procedures to reduce organizational sources of stress, and (c) the establishment of employee assistance programs. In one study, after stress prevention activities were implemented in a 700-bed hospital, the frequency of medication errors declined by 50%. In a second study, malpractice claims were reduced by 70% in 22 hospitals that implemented stress prevention activities, while no reduction in malpractice claims was found in a matched group of 22 hospitals where stress prevention activities were not instigated.

RESOURCES REQUIRED

NIOSH will work directly with any organization to gather the necessary tools to create change within a given organization. NIOSH will provide information and technical assistance, as well as videotapes and other training materials, all free of charge. Successful implementation of this kind of strategy will require a specialized technical support team, plus the cooperation of personnel at all levels of the base organization. In addition, it may be necessary or beneficial to hire one or more psychologists as consultants to assist with preliminary assessment, intervention design, and/or effectiveness evaluation. Fees will vary depending on the nature and amount of consultant involvement.

WHERE TO FIND MORE INFORMATION

National Institute for Occupational Safety and Health
Hubert H. Humphrey Bldg.
200 Independence Ave., SW
Room 715H
Washington, DC 20201
TOLL-FREE: (800) 356-4674; from outside the U.S.: (513) 533-8328
Fax: (513) 533-8573
Email: eidtechinfo@cdc.gov
URL: www.cdc.gov/niosh/stresshp.html

State psychological associations maintain a listing of licensed psychologists who may be able to help with stress-related issues. Contact the American Psychological Association (APA; see below) or your State psychological association for more information, or refer to the APA internet site with this information (http://helping.apa.org/find.html).

American Psychological Association (APA)
750 First St., N.E.
Washington, DC 20002-4242
TOLL-FREE: (800) 374-2721
Tel: (202) 336-5500

Organizational Factors References

Introduction

European Commission. (1997). *Report on work-related stress.* Brussels: Author.

Fujigaki, Y. (1993). Stress analysis: A new perspective on peopleware. *American Programmer, 6,* 33-38.

Goetzel, R. Z., Anderson, D. R., Whitmer, R. W., Ozminkowski, R. J., Dunn, R. L., Wasserman, J., et al. (1998). The relationship between modifiable health risks and health care expenditures.: An analysis of the multi-employer HERO health risk and cost database. *Journal of Occupational and Environmental Medicine, 40,* 843-854.

Isen, A. M., Daubman, K. A., & Nowicki, G. P. (1987). Positive affect facilitates creative problem solving. *Journal of Personality and Social Psychology, 52,* 1122-1131.

Murphy, L. R. (1996). Stress management in the work settings: A critical review of health effects. *American Journal of Health Promotion, 10,* 112-135.

Sauter, S. L., Murphy, L., Colligan, M., Swanson, N., Hurrel, J., Jr., Scharf, F., Jr., et al. (1999). *Stress . . . at work* (DHHS Publication No. 99-101).Cincinnati, OH: National Institute for Occupational Safety and Health.

Sauter, S. L., Murphy, L. R., & Hurrell, J. J. (1990). Prevention of work-related psychological disorders: A national strategy proposed by the National Institutes for Occupational Safety and Health (NIOSH). *American Psychologist, 45,* 1146-1158.

Personal Stereo Use

Oldham, G. R., Cummings, A., Mischel, L. J., Schmidtke, J. M., & Zhou, J. (1995) Listen while you work? Quasi-experimental relations between personal-stereo headset use and employee work responses. *Journal of Applied Psychology, 80,* 547-564.

Wyatt, S., & Langdon, J. N. (1937). Fatigue and boredom in repetitive work. *Industrial Health Research Board Report No. 77.* London: Her Majesty's Stationery Office.

Stress...At Work

Sauter, S. L., Murphy, L., Colligan, M., Swanson, N., Hurrel, J., Jr., Scharf, F., Jr., et al. (1999). *Stress . . . at work* (DHHS Publication No. 99-101).Cincinnati, OH: National Institute for Occupational Safety and Health.

Work Group Cohesiveness

Introduction

"Work group cohesiveness" refers to the ability of a work group to trust and communicate with one another, to work together as a team. It can be a tremendous challenge to take a diverse group of employees and turn them into a cohesive unit that integrates well with the entire organization. The fact that people differ means that conflict will almost inevitably arise (Rayeski & Bryant, 1994, p. 217). Conflicts can occur among individual members or between the team and the rest of the organization (Capozzoli, 1995; Amason, 1996; Kezsbom, 1992).

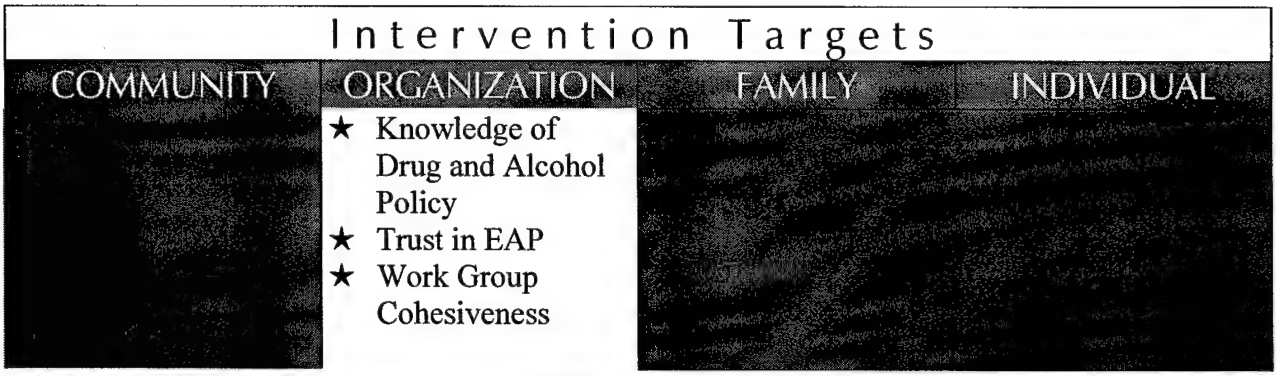
In spite of the potential obstacles, however, there are tremendous potential benefits to building cohesive work groups. Employees in such groups are less likely to report individual job stress, problem drinking, and climates that support drinking (Bennett & Lehman, 1998; Delaney & Ames, 1995). In theory, this is at least partly because a work group that is unified is more aware of its membership. If one member of a cohesive team is faltering — be it in the form of personal stress, substance use, or inability to meet the demands of the job — the other members are likely to lend support and take the necessary steps to assist the member in need (Bennett, Lehman, & Reynolds, 2000). There are benefits for the organization as well. For example, teams that work well together are able to execute and make necessary adjustments to assigned tasks more efficiently than a team that is not cohesive (Mohrman, Cohen, & Mohrman, 1995). Thus, promoting cohesive units can also improve and/or protect organizational efficiency and productivity (see Capozzoli, 1995).

The intervention listed below (*Team Awareness*) has been shown to significantly improve work group cohesiveness, particularly in areas relevant to drug and alcohol use and abuse.

Items in 2003 AF Community Assessment	Item #s
1. Good relationships with coworkers, supervisor, and supervisees	F1
2. Members of squadron are cohesive	G1a
3. Members of squadron work together as a team	G1b
4. Trust that squadron members, officers, and NCOs will perform well in a deployment or crisis situation	G1d-f

Activities/Interventions
Team Awareness

Team Awareness



DESCRIPTION

Team Awareness is a workplace-based training strategy that was designed to address behavioral and organizational risks for substance abuse among employees and their coworkers (Bennett, Lehman, & Reynolds, 2000). The intervention increases employees' motivation to seek help for their own problems and enhances team awareness of peers who may be in need of assistance. The intervention helps both individuals and the team to meet desired outcomes by promoting group cohesiveness, improving communications among team members and between team members and management, and strengthening awareness of potential risk factors for the employee and the organization.

During Team Awareness training, the facilitator uses a combination of lecture, group discussion, small group exercises, and innovative games to accomplish the following goals:

- Increase employees' awareness of the importance of their role in substance abuse prevention in their worksite.
- Create positive attitudes toward company policies as tools for risk prevention.
- Reduce risky levels of supervisor and coworker tolerance of substance abuse.
- Increase awareness of the nature of stress and its risk factors and consequences, including the role of substance use. Promote healthy alternatives for dealing with stress.
- Improve workplace communication skills by reviewing listening skills and identifying work communication norms.
- Develop peer referral skills and employee alliance with Employee Assistance Programs (EAPs).

MINIMAL IMPLEMENTATION

The intervention developer and/or on-site facilitator first conduct preliminary focus groups and hold preparatory meetings in order to collect information regarding organizational policy and to tailor the intervention to fit the needs and resources of the specific organization. The actual team-oriented awareness training is an 8-hour activity administered across two 4-hour group sessions, held two weeks apart. Each group is

composed of 10 to 25 employees — most often people who work closely with one another.

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Team Awareness is the first workplace-based training recognized as a Model Program by the Substance Abuse and Mental Health Services Administration. It has been shown to enhance trust within work groups, improve communications, and strengthen employees' knowledge of and trust in EAPs and organizational policies (Bennett & Lehman, 2001; Lehman, Reynolds, & Bennett, 2003). At six-month follow-up, compared to others within their organizations, employees who participated in Team Awareness were also:

- Twice as likely to decrease problem drinking behaviors
- Less likely to arrive at work under the influence of drugs or alcohol
- Less likely to work with or miss work due to a hangover
- More likely to work in a group that encourages coworkers to stop a drinking or drug habit
- More likely to contact their EAP for help

RESOURCES REQUIRED

Once at least one base representative has been trained as an on-site intervention facilitator, it may only be necessary to consult the intervention developers when technical assistance is required. Training costs approximately $3000 per facilitator; however, group discounts are available. Manuals and other materials are available free of charge and can be downloaded at www.organizationalwellness.com.

WHERE TO FIND MORE INFORMATION

Joel B. Bennett, Ph.D.
Organizational Wellness & Learning Systems
4413 Overton Terrace
Fort Worth, TX 76109
Tel: (817) 921-4260
Email: owls@charter.net
URL: www.organizationalwellness.com

Work Group Cohesiveness References

Introduction

Amason, A. C. (1996). Distinguishing the effects of functional and dysfunctional conflict on strategic decision making: Resolving a paradox for top management teams. *Academy of Management Journal, 39,* 123-148.

Bennett, J. B., & Lehman, W. E. K. (1998). Workplace drinking climate, stress, and problem indicators: Assessing the influence of teamwork (group cohesion). *Journal of Studies on Alcohol, 59,* 608-618.

Bennett, J. B., Lehman, W. E. K., & Reynolds, S. (2000). Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program. *Prevention Science, 1,* 157-172.

Capozzoli, T. K. (1995). Conflict resolution: A key ingredient in successful teams. *Supervision, 56,* 3-5.

Delaney, W. P., & Ames, G. (1995). Work team attitudes, drinking norms, and workplace drinking. *Journal of Drug Issues, 25,* 275-290.

Kezsbom, D. S. (1992). Bringing order to chaos: Pinpointing sources of conflict in the nineties. *Cost Engineering, 34,* 9-16.

Mohrman, S. A., Cohen, S. G., & Mohrman, Jr., A. M. (1995). *Designing team-based organizations: New forms for knowledge work.* San Francisco, CA: Jossey-Bass.

Rayeski, E., & Bryant, J. D. (1994). Team resolution process: A guideline for teams to manage conflict, performance, and discipline. In M. Beyerlein & M. Bullock (Eds.), *The International Conference on Work Teams Proceedings: Anniversary Collection. The Best of 1990 - 1994* (pp. 215-221). Denton, TX: University of North Texas, Center for the Study of Work Teams.

Varney, G. H. (1989). *Building productive teams: An action guide and resource book.* San Francisco, CA: Jossey-Bass, Inc.

Team Awareness

Bennett, J. B., & Lehman, W. E. K. (2001). Workplace substance abuse prevention and help seeking: Comparing team-oriented and informational training. *Journal of Occupational Health Psychology, 6,* 243-254.

Bennett, J. B., Lehman, W. E. K., & Reynolds, S. (2000). Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program.

Lehman, W. E. K., Reynolds, G. S., & Bennett, J. B. (2003). Team and informational trainings for workplace substance abuse prevention. In J. B. Bennett & W. E. K. Lehman, (Eds.), *Preventing workplace substance abuse: Beyond drug testing to wellness* (pp. 165-201) Washington, DC: American Psychological Association.

Marital/Romantic Relationships

Introduction

Successful, satisfying couple relationships promote physical, mental, and interpersonal health, whereas unsuccessful, conflicted relationships negatively affect many aspects of well-being and create financial and social burdens for communities (see Waite & Gallagher, 2000, for a review). Unfortunately, at present, marriages in America are more likely to be unsuccessful than not. Between 40% and 50% of U.S. couples currently marrying for the first time will eventually divorce (Kreider & Fields, 2002). Of course, not all distressed relationships are reflected in divorce rates — many couples never divorce, remaining in distressed relationships (Notarius & Markman, 1993). Indeed, one in five married couples reports significant marital dissatisfaction at any given time (Beach & O'Leary, 1986). Furthermore, most distressed relationships have at least one incident of physical aggression per year (Heyman & Slep, 2003).

Many distressed couples seek professional help for their problems and there is good evidence that some forms of couples' therapy are better than no help at all — at least for a time (e.g., Hahlweg & Markman, 1988). However, it has been argued that rather than merely trying to fix relationships that are already "broken," it may be more effective to provide relatively satisfied couples with information and skills that can help prevent marital problems from developing (Behrens & Sanders, 1992; Carroll & Doherty, 2003; Sayers, Kohn, & Heavey, 1998).

The interventions listed in this section have been shown to significantly reduce and/or prevent marital conflict and distress. One (PREP) has been designed for and primarily evaluated with premarital couples and newlyweds, while the others are known to be effective with longer-married couples.

Items in 2003 AF Community Assessment	Item #s
1. Perception of good relationship	M6a
2. Stability	M6b
3. Equal partnership	M6c
4. Commitment	M6d
5. Happiness	M7

Activities/Interventions
Prevention and Relationship Enhancement Program (PREP)
Relationship Enhancement (RE)
Couples Coping Enhancement Training (CCET)
Triple P (Levels 4 & 5 only)

Prevention and Relationship Enhancement Program (PREP)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Marital/Romantic Relationships	

DESCRIPTION

Negative patterns of communication (e.g., hostility, withdrawal, domineering) are strongly associated with couple distress, violence, and breakup (Holtzworth-Munroe, et al., 1995; Markman, Floyd, Stanley, & Storaasli, 1988; Gottman & Krokoff, 1989). The Prevention and Relationship Enhancement Program (PREP) is primarily designed to help couples communicate — without fighting — about sensitive issues and areas of conflict, and to enhance commitment, sensuality, friendship, and fun.

PREP participants hear lectures and view videotapes on communication skills, identify issues relevant to their relationships, and are assigned to practice important skills at home. In some versions of PREP, trained consultants coach couples through in-session practices. Readings are often assigned from the book *Fighting for Your Marriage* (Markman, Stanley, & Blumberg, 2001).

MINIMAL IMPLEMENTATION

In the most intense version of PREP, participants attend six 2-hour weekly sessions in groups of four to eight couples. However, more typical formats consist of either (a) 4-8 couples attending three sessions (one weekend day followed by two weekday evenings), or (b) a weekend seminar, which may involve groups of 20-40 couples at a time. There is evidence that the weekend format can be as effective as the more extended versions (Hahlweg, Markman, Thurmaier, Engl, & Eckert, 1998).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

PREP has been more extensively researched regarding long-term effectiveness than other interventions, with almost all this research focusing on effects with premarital couples. (There is little empirical evidence so far that PREP is effective for longer-married couples, although it is often used with them.) Three years after program participation, PREP couples had higher levels of relationship satisfaction and sexual satisfaction and lower problem intensity than matched control couples (Markman, Floyd, Stanley, & Storaasli, 1988). Four to five years after participation, PREP participants continued to interact more positively and communicate less negatively with each other than both matched control couples and couples who had declined the intervention years earlier (Markman, Renick, Floyd, Stanley, & Clements, 1993). Notably, PREP couples reported fewer instances of physical violence with their spouse than did control couples across three- to five-year follow-ups.

RESOURCES REQUIRED

Training for PREP trainers and all necessary materials are available from PREP Inc. Trainers need not be mental health professionals (Stanley et al., 2001). Training costs roughly $450/individual and $675/couple, which includes basic training materials. Training is conducted at various sites around the world; to host a training session on base, contact PREP Inc. for costs and scheduling.

WHERE TO FIND MORE INFORMATION

PREP Inc.
P.O. Box 102530
Denver, CO 80250
TOLL-FREE: (800) 366-0166
Tel: (303) 759-9931
Fax: (303) 759-4212
Email: info@prepinc.com
URL: www.prepinc.com

Relationship Enhancement (RE)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Marital/Romantic Relationships	

DESCRIPTION

People who are unable to express their feelings to their partners and/or to listen to and understand their partners' feelings often end up with troubled relationships. The Relationship Enhancement (RE) intervention, first pioneered in the 50's and 60's, was designed to enhance and enrich marital relationships by enabling spouses to communicate empathically.

RE participants are taught how to maximize self-disclosure, as well as how to listen and understand with empathic acceptance. These skills are practiced both during the intervention sessions and at home.

MINIMAL IMPLEMENTATION

In the RE intervention, participants generally attend weekly 2- to 2 ½-hour small-group sessions for 6 to 12 weeks. The intervention is also often offered in a weekend seminar format; however, there is not yet any empirical evidence of the weekend seminar's effectiveness.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Over the past 30 years, many studies have established the effectiveness of the RE intervention (see Accordino & Guerney, 2002, for a comprehensive review). Unlike PREP (see page 32), the long-term effectiveness of RE has not been demonstrated beyond one year after participation. However, compared to PREP, there is stronger evidence that RE can improve the relationships of couples who have been together for several years and/or are already distressed (e.g., Brock & Joanning, 1983; Brooks, 1997; Griffin & Apostal, 1993). In 1985, a study of the evidence for 12 different marital enrichment interventions found that RE was by far the most effective (Giblin, Sprenkle, & Sheehan, 1985). According to this study, the average individual in an RE group does better than 83% of those in a control group.

RESOURCES REQUIRED

Group leaders need not be mental health professionals (Collins, 1977). Training for RE group leaders and all necessary materials are available from the National Institute of Relationship Enhancement (NIRE). Training possibilities include a cost-effective videotaped training activity, with coaching by phone, which was recently developed to train group leaders by distance education. The complete videotaped home study training intervention costs $495, plus shipping and handling.

WHERE TO FIND MORE INFORMATION

NIRE
4400 East-West Hwy., Suite 28
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Tel: (301) 986-1479
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Email: info@nire.org
URL: www.nire.org

Couples Coping Enhancement Training (CCET)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Marital/Romantic Relationships ★ Perceived Family Coping	★ Perceived Personal Coping

DESCRIPTION

Stress is a fact of life, and couples who have a hard time coping are (a) more likely to have unstable, unsatisfying relationships that deteriorate over time, and (b) at higher risk for divorce (Bodenmann, 1997; Bodenmann & Cina, 1999). Couples Coping Enhancement Training (CCET) is an innovative intervention designed to improve marital relationships by increasing participants' ability to cope with stress — both as individuals and as couples.

Developed in Switzerland less than 10 years ago, CCET includes training in communication skills similar to those that are taught in other interventions (e.g., PREP). However, CCET is unique in that its primary focus is enhancing coping abilities. Couples hear lectures and stories and see videos about stress and coping. They also see role plays showing healthy ways to cope with stress individually and together, and are coached through practical coping and communication exercises.

MINIMAL IMPLEMENTATION

In the studies conducted so far, CCET participants met in groups of four to eight couples with one trainer for every two couples. (The developers are currently experimenting with more cost-effective formats.) The workshop typically takes place over a weekend (Friday evening to Sunday evening), lasting a total of 18 hours.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Notably, research on CCET has involved couples who had been together for 1 to 33 years (the average was about 14), not just newlyweds or young couples. Six months after participation, CCET couples were arguing less often than control couples (Bodenmann, Widmer, & Cina, 1999). After one year, CCET couples were more likely to report increases in marital quality and satisfaction, as well as in their problem-solving and coping abilities (Bodenmann, Charvoz, Cina, & Widmer, 2001). Even after two years, intervention participants reported using more healthy and fewer dysfunctional coping strategies than controls (Bodenmann, Perrez, Cina, & Widmer, 2002).

RESOURCES REQUIRED

The manual necessary to train CCET trainers should be available in English by the end of 2003. All trainers in the studies discussed above were psychology students or mental health professionals; however, research is currently underway utilizing clergy and other paraprofessionals as trainers.

WHERE TO FIND MORE INFORMATION

Institute for Family Research and Counseling
Av. de la Gare 1
CH-1700 Fribourg
SWITZERLAND
Tel: +41 (0)26/300 73 60
Email: institut-famille@unifr.ch
URL: http://www.unifr.ch/iff/e/indexen.html

Triple P (see page 49)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Marital/Romantic Relationships ★ Perceived Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depression (Levels 4 & 5 only) ★ Perceived Personal Coping ★ Anxiety (Levels 4 & 5 only)

Marital/Romantic Relationships References

Introduction

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Prevention and Relationship Enhancement Program (PREP)

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Markman, H. J., Stanley, S., & Blumberg, S. L. (2001). *Fighting for your marriage: New and Revised.* San Francisco: Jossey-Bass.

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Relationship Enhancement (RE)

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Griffin, J. M., Jr., & Apostal, R. A. (1993). The influence of relationship enhancement training on differentiation of self. *Journal of Marital & Family Therapy, 19,* 267-272.

Couples Coping Enhancement Training (CCET)

Bodenmann, G. (1997). The influence of stress and coping on close relationships: A two-year longitudinal study. *Swiss Journal of Psychology, 56,* 156-164.

Bodenmann, G., Charvoz, L., Cina, A., & Widmer, K. (2001). Prevention of marital distress by enhancing the coping skills of couples: 1-year follow-up study. *Swiss Journal of Psychology, 60,* 3-10.

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Perceived Family Coping Ability

Introduction

Every family experiences stress in one form or another. However, the stressful lifestyle of modern military families is almost beyond compare (see Hunter, 1982). As (Black (1993, p. 273) points out:

> Life stressors faced by military families include frequent moves, the potential of being deployed into hostile environments,...the threat that their loved ones may be killed or wounded in combat or military accidents,...frequent periods of family separation, geographic isolation from extended-family support systems, low pay, young age as compared to the general population, and a high incidence of young children living in the home. Each stressor might be adequately handled by families when dealt with separately, but military families often must deal with them as an aggregate.

It should also be noted that these stressors — difficult enough to deal with on their own — can create or contribute to relationship problems within families, which in turn create more stress. Given such potential for stressful circumstances and events in military family life, it is essential that service members and their families possess the ability to cope well during difficult times — both as individuals (see page 79) and as family units. The interventions listed in this section have been shown to help couples and/or families work together to overcome life's many challenges. While all three programs teach skills that are applicable to many kinds of stressful life events, one (CCET) has a special focus on coping as a couple, while the others are designed to improve the coping abilities of families with young children.

Items in 2003 AF Community Assessment	Item #s
1. Family works together as a team	M5a
2. Family keeps a positive perspective during tough times	M5b
3. Family has good problem-solving abilities	M5

Activities/Interventions
Incredible Years ADVANCE
Triple P
Couples Coping Enhancement Training (CCET)

Incredible Years ADVANCE (Ages 3-8)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Perceived Family Coping	

DESCRIPTION

Incredible Years ADVANCE is a videotape-based parent training series for parents of 3-8 year olds. (This was the age range in the validation study; however, the Incredible Years website states that the intervention is suitable for use with parents of 4-10-year olds). This intervention was designed to supplement the Incredible Years BASIC intervention (see page 54). The ADVANCE series builds on the BASIC intervention by focusing on parents' interpersonal issues, especially those related to family coping. The subjects covered in the intervention include effective communication and problem solving skills, anger management, ways to give and get support, and teaching problem solving skills to children.

The ADVANCE videotapes contain over 2 ½ hours of brief scenes showing parents interacting with each other and/or with their children. Group leaders use these scenes to help teach new skills and facilitate group discussion and problem solving. Parents discuss the principles taught and practice the skills through role-playing and home practice assignments.

MINIMAL IMPLEMENTATION

The ADVANCE series is intended to be implemented with parents who have already completed an Incredible Years BASIC group intervention. Participants meet in groups of 10-14 parents; the ADVANCE intervention can be completed in 8 to 10 weekly, 2-hour sessions. Typically, only the primary caregiving parent attends the sessions. Although the ADVANCE intervention could theoretically be self-administered, there is as yet no evidence that it is effective in any other than a group format.

It should be noted that participating parents rate this intervention as extremely useful and express high consumer satisfaction. In fact, of 38 families randomly assigned to attend the ADVANCE intervention (after already having attended 10-12 weekly 2-hour BASIC sessions), only one family dropped out of the intervention (Webster-Stratton, 1994). All of the remaining families attended over two-thirds of the ADVANCE sessions, with most attending over 90%.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

In 1994, Webster-Stratton randomly assigned parents to receive both BASIC and ADVANCE training, while some parents attended only the BASIC intervention.

Compared to BASIC-only parents, mothers and fathers who also attended the ADVANCE groups demonstrated the following:

- More positive communication with each other
- Better problem-solving skills
- Children who were better problem solvers
- Greater ability to work as a team
- Higher consumer satisfaction

RESOURCES REQUIRED

At least one set of Incredible Years ADVANCE videotapes per site (cost: $775 plus shipping and handling; multiple sets can be ordered at a discount) per site, a VCR in which to play them, and preferably a blackboard or easel and pad for the group leader to use. (It may also be possible to obtain permission to broadcast the Incredible Years videotapes to the base community.) All intervention-specific resources — including group leader training, videos, manuals, and handouts — are available from Incredible Years. Introductory training for group leaders lasts three days. These training workshops are offered regularly in Seattle (cost: $400/person for registration, $30/person for training materials, plus travel, lodging, and meals), and certified Incredible Years trainers are also available to go on-site to train leaders if there are a minimum of 15 participants (cost: $1300/day trainer fee for 3 days, $650 half-day travel fee, plus trainer's travel, lodging, and meals, as well as $30/participant for training materials).

WHERE TO FIND MORE INFORMATION

Incredible Years
1411 8th Ave. West
Seattle, WA 98119
Tel: (206) 285-7565
TOLL-FREE: (888) 506-3562
Email: incredibleyears@seanet.com
URL: www.incredibleyears.com

Triple P (see page 49)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Marital/Romantic Relationships ★ Perceived Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depression (Levels 4 & 5 only) ★ Perceived Personal Coping ★ Anxiety (Levels 4 & 5 only)

Couples Coping Enhancement Training (CCET) (see page 36)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Marital/Romantic Relationships ★ Perceived Family Coping	★ Perceived Personal Coping

Perceived Family Coping Ability References

Introduction

Black, W. G., Jr. (1993). Military-induced family separation: A stress reduction intervention. *Social Work, 38*, 273-280.

Hunter, E. J. (1982). *Families under the flag: A review of military family literature.* New York: Praeger.

Incredible Years ADVANCE (Ages 3-8)

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology, 62*, 583-593.

Parent-Child Relationships

Introduction

As with couple relationships, satisfaction with parent-child relationships is viewed as an indicator of relationship quality. However, when it comes to improving the relationship, parenting satisfaction — like couple satisfaction — is rarely (if ever) a direct target of change. Parenting satisfaction is closely associated with levels of behavior problems in children and with how capably parents are able to manage the problems that occur (Coleman & Karraker, 2000; Johnston & Mash, 1989; Kurdek, 1998), and it is these factors that are usually the targets of parenting interventions.

Dozens of different interventions have been designed to reduce child behavior problems and enhance parents' ability to handle their children. However, many of these interventions have not been empirically validated and/or would not be feasible or practical in the context of NORTH STAR. In this section, we present six interventions that both (a) have good evidence that they can improve parenting abilities and reduce or prevent child behavior problems, and (b) could be cost-effectively and universally implemented by an Air Force base. Two of the interventions (i.e., Cognitive Appraisal Program, Triple P Levels 4 & 5) have also been shown to impact other risk factors targeted by NORTH STAR (e.g., Depression, Perceived Personal and Family Coping). Each of the interventions was designed for parents of children within a different age range, and all age ranges from birth to 18 years old are covered by at least one of the interventions.

Items in 2003 AF Community Assessment	Item #s
1. Satisfaction with overall relationship with kids	N7

Activities/Interventions
Cognitive Appraisal Program
Triple P
Incredible Years BASIC
Guiding Good Choices
Parenting Wisely
RETHINK

Cognitive Appraisal Program (Ages birth-1)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships Special Needs of Child(ren)	★ Depression

DESCRIPTION

Many communities have home visitation programs that are intended to help and support parents — especially mothers — of new infants, and to enhance family functioning and child health. The Cognitive Appraisal Program is a brief, innovative feature designed to be incorporated into and increase the positive impact of such programs.

During the cognitive appraisal discussions, parents are asked for examples of caregiving problems they may be having. They are helped to think through the possible reasons for a specific problem and to design a strategic plan for solving the problem in the future. The success of the chosen strategy is discussed at the next visit, and the plan is modified as needed. "The goal of the program is to give parents repeated experience in finding new ways (directed away from self- or child-blame) of explaining problems and in finding new ways of resolving those problems" (Bugental et al., 2002, p. 247).

MINIMAL IMPLEMENTATION

The cognitive appraisal discussion is quite brief, and is usually to be conducted at the start of each home visit. In the study evaluating the program, the goal was to visit each family 20 times during the first year of the infant's life; the average number of visits actually completed per family was 17.

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Although this program is quite new, the evidence for it so far is quite impressive (Bugental et al., 2002). In the study, moderately distressed families were randomly assigned to receive either (a) no home visits, (b) a home visitation program based on the well-known Hawaii Healthy Start program (Breakey & Pratt, 1991; Mitchel-Bond & Cohn-Donnelly, 1993), or (c) the same home visitation program "enhanced" with the cognitive appraisal component. While the "unenhanced" home visitation program did lead to improved child health, it did not seem to affect family functioning. The addition of the cognitive appraisal component, however, led to improved parent-child relationships, healthier ways of parental thinking about caregiving problems, less harsh parenting, and decreased maternal depression. These effects were especially strong in those families where the infant was medically at-risk (i.e., had low Apgar scores or was premature). In fact, the percentage of mothers who reported physically abusing their infants during the first year was 26% in the no-visit group and 23% in the "unenhanced" home visitation group, but only *4%* in the group who received home visits with the additional cognitive appraisal component.

RESOURCES REQUIRED

The home visitors employed in the program evaluation were paraprofessionals who were supervised by a licensed clinical social worker. Training materials for the Cognitive Appraisal Program should be available in 2003; for more information, contact the program developer (see below).

WHERE TO FIND MORE INFORMATION

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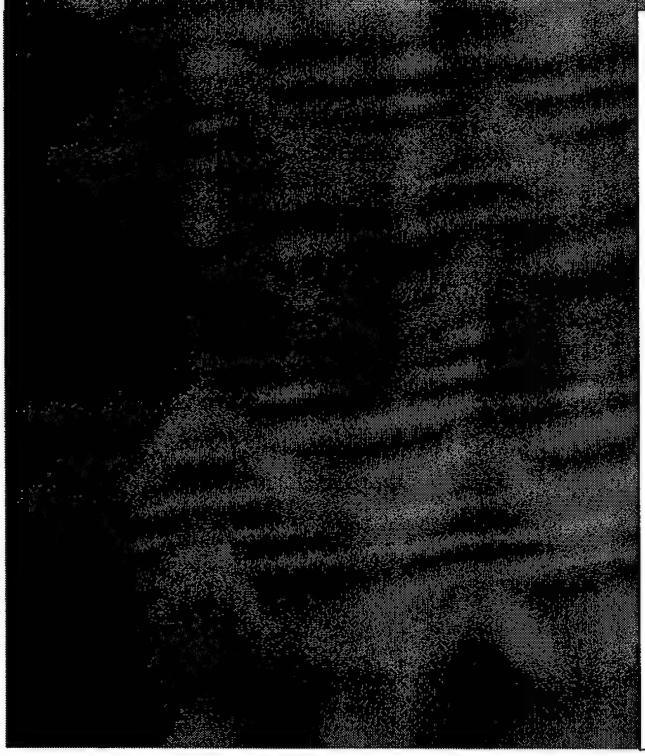
Triple P (Ages birth-12)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Marital/Romantic Relationships ★ Perceived Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depression (Levels 4 & 5 only) ★ Perceived Personal Coping ★ Anxiety (Levels 4 & 5 only)

DESCRIPTION

Triple P ("Positive Parenting Program") is a multi-level family support strategy that aims to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents.

Originally developed in Australia, Triple P was designed around the idea that parents have differing needs and desires regarding the type, intensity and mode of assistance that they may require. The Triple P system is designed to maximize efficiency, contain costs, and ensure that the program has wide reach in the community. Thus, Triple P consists of five possible levels of intervention for parents of children from birth to age 12. The five levels are of increasing intensity, as described below. Families can enter the Triple P system of intervention at any level. The system does not require families to progress from the least to most intensive level of intervention, although this may occur. Having completed one level of Triple P does not mean a particular family cannot complete another, and some families should certainly be encouraged to do so.

Level 1: A community-wide, multimedia parent information campaign. Goals include promoting awareness of parenting issues and normalizing participation in parenting programs such as Triple P.

Level 2: A very brief, 1- or 2-session primary care intervention for parents of children with mild behavior problems. Parents receive specific advice on how to solve common child developmental issues (e.g., potty training) and minor child behavior problems (e.g., bedtime problems).

Level 3: A brief primary care program for parents of children with mild to moderate behavior difficulties. The program combines advice with active skills training as required to teach parents to manage a discrete child problem behavior (e.g. tantrums, fighting with siblings).

Level 4: A broadly focused parenting program for parents who want or need intensive training in positive parenting skills (often, these are parents of children with more severe behavior problems). Parenting skills are taught and practiced across a range of target behaviors, settings, and children.

Level 5: An intensive, individually-tailored program for families where parenting difficulties are complicated by other sources of family distress (e.g., relationship conflict, parental depression, and/or high levels of stress). Possible program elements include practice sessions to enhance parenting skills, mood management and stress coping skills, and partner support skills.

MINIMAL IMPLEMENTATION

Bases implementing Triple P as part of NORTH STAR may choose to apply any one or any combination of the five levels. Implementation by level involves the following:

Level 1: Community-wide use of print and electronic media and other health promotion strategies. May include some contact with professional staff (e.g., via telephone).

Level 2: Guidance with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies. May involve either (a) about 20 minutes (total over 2 sessions) of face-to-face or telephone contact with a primary care service provider or (b) a 60-90 minute seminar. Level 2 providers may come from maternal and child health services, family health care, childcare centers, kindergartens, preschools, schools, and/or other community agencies that offer parent support.

Level 3: About 80 minutes (total over four sessions) of either face-to-face or telephone contact with a primary care service provider. Same potential providers as Level 2.

Level 4: About 10 hours (total over 8-10 sessions). Possible formats include individual, group (groups usually consist of 10-12 parents), or self-directed (with or without telephone assistance) options.

Level 5: Up to 11 face-to-face, individualized sessions lasting 40-90 minutes each.

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

All five levels of Triple P are being rigorously validated (for reviews see Sanders, 1999; Sanders, Turner, & Markie-Dadds, 2002). In general, all five levels have been found to reduce child behavior problems, increase parents' sense of competence, and improve

parent-child relationships. As might be expected, families who participated in more intense versions of the program generally tended to see more dramatic results. In addition, the two highest levels (i.e., 4 and 5) of Triple P have demonstrated the following effects:

- Reduced mothers' depression
- Reduced mothers' and children's anxiety
- Improved children's self-esteem
- Reduced parental stress
- Reduced marital conflict and increased marital satisfaction
- Improved parents' perceived ability to work together as a team

RESOURCES REQUIRED

Required resources will vary greatly depending on the level(s) to be implemented. However, the materials and training necessary for any and all of the five levels are available from Triple P International or Triple P America. Training courses are conducted either at Triple P America headquarters in South Carolina or on-site and are available for levels 2 & 3 (combined) and levels 4 & 5 (combined or separate). Each course is presented to up to 22 trainees and lasts 3-6 days total, with the final day of training scheduled 6-8 weeks following completion of the rest of the course. Training ranges in price from about $500 to $1500 per participant, plus travel, lodging, and materials.

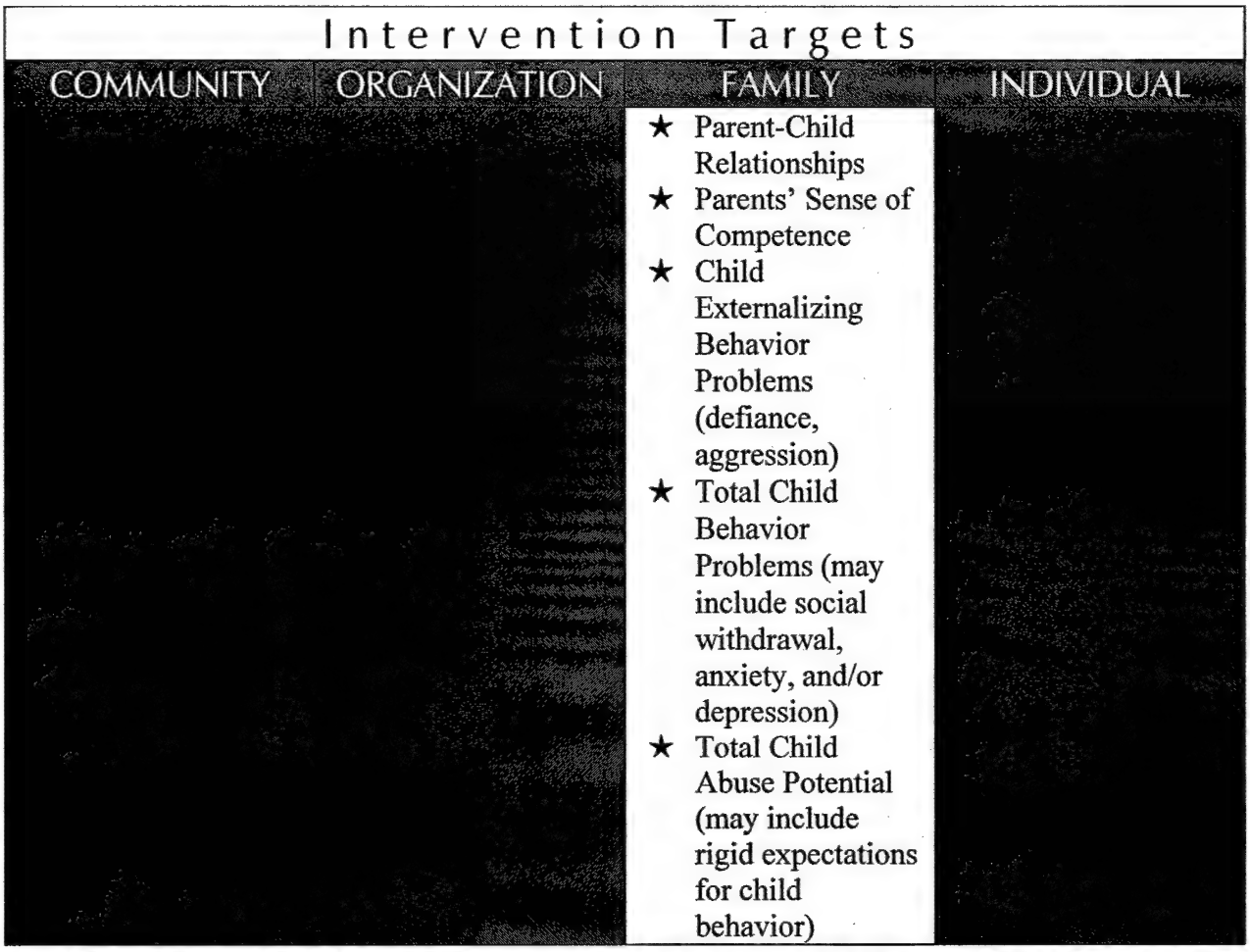
WHERE TO FIND MORE INFORMATION

Triple P International
Email: info@triplep.net
URL: www.triplep.net

For training and materials in the U.S., contact:

Triple P America
4840 Forest Drive #308
Columbia, SC 29206
Tel: (803) 787-9944
Email: triplepa@bellsouth.net
URL: www.triplep-america.com

Common Sense Parenting (Ages 2-17)



DESCRIPTION

Common Sense Parenting (CSP) is a parent training intervention designed to teach practical child management skills to parents. Skills taught during the course of the intervention include:

- Developing family rules;
- Using consequences to correct negative behaviors;
- Using praise to teach and encourage positive behaviors;
- Reaching goals with charts and contracts;
- Thinking ahead to prevent problems;
- Teaching children to remain calm in difficult situations;
- Teaching children to make decisions and solve problems.

During training sessions, CSP trainers teach these parenting skills by means of presentations, discussions, videotaped examples, live role-plays, and homework assignments.

MINIMAL IMPLEMENTATION

The original version of CSP includes a 60-minute assessment interview with each parent or set of parents — typically conducted in their homes — plus 8 weekly 2-hour group sessions led by two CSP trainers. An abbreviated version consisting only of 6 weekly 2-hour group sessions led by one trainer has been found to be equally effective. In either case, individual meetings with trainers may also be made available to parents who need or desire them. Support and follow-up may also include telephone consultations between sessions and/or following completion of the intervention.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Repeated evaluations of CSP (Ruma, Burke, & Thompson, 1996; Thompson, Grow, Ruma, Daly, & Burke, 1993; Thompson, Ruma, Brewster, Besetsney, & Burke, 1997; Thompson, Ruma, Schuchmann, & Burke, 1996) have shown that parents feel more competent and are better problem-solvers after participating in the intervention. Importantly, participants also reported fewer behavior problems with their children; these effects were maintained at 3-month follow-up. In addition, participating parents demonstrated increased satisfaction with family relationships and a significant decrease in child abuse potential. The intervention has been shown to be effective for parents of children of all ages between 2 and 17 and for both middle- and low-income families.

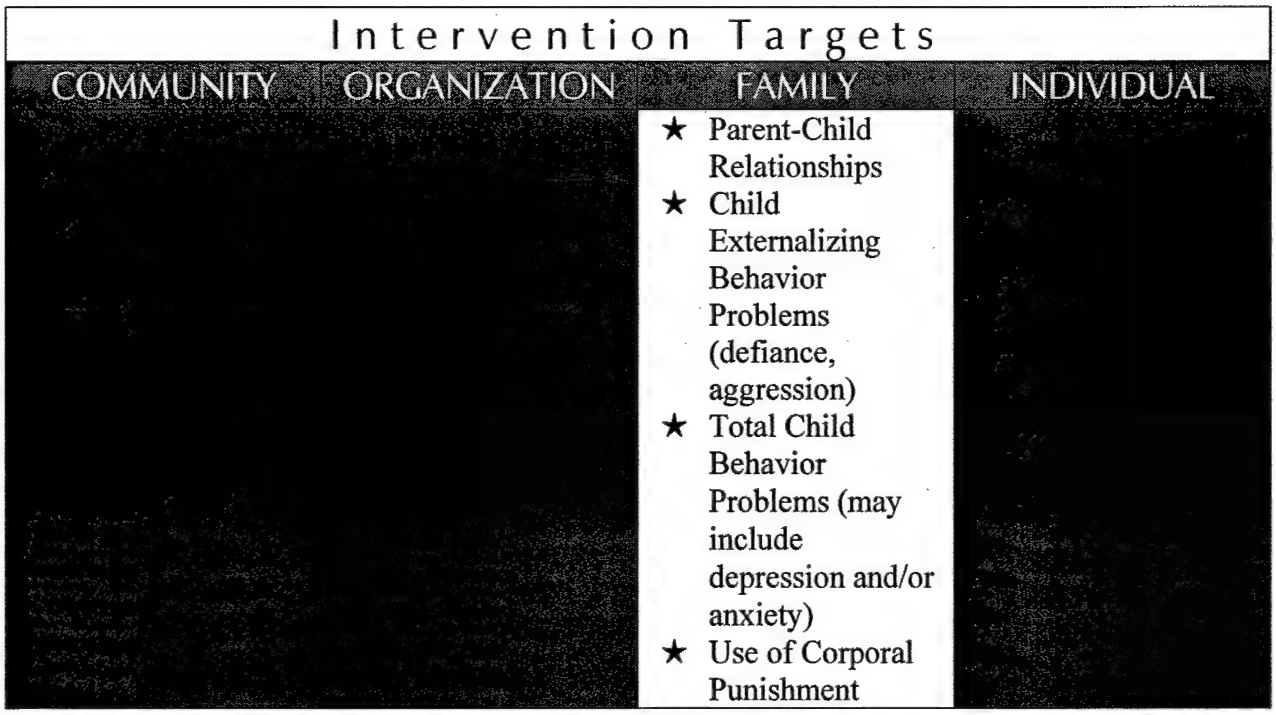
RESOURCES REQUIRED

At a minimum, trainers will need a meeting room, VCR, and television along with the course materials. In the standard CSP intervention, including home visitation, group meetings, and follow-up, it was estimated that the intervention required about 70 hours of staff time to serve 10 families, at a cost of $160 per family. In the abbreviated intervention, staff time was cut down to 30 hours to serve 10 families at a cost of $70 per family (Thompson et al., 1996). Training workshops last for 4 days and are offered at Boys Town in Nebraska or on-site. For the training at Boys Town, the cost is $675 per person.

WHERE TO FIND MORE INFORMATION

Girls and Boys Town National Resource and Training Center
14100 Crawford St.
Boys Town, NE 68010
TOLL-FREE: (800) 545-5771
Fax: 402-498-1500/1501
Email: nrtcmarketing@girlsandboytown.org
URL: www.girlsandboystown.org/pros/training/family/index.asp

Incredible Years BASIC (Ages 3-8)



DESCRIPTION

Incredible Years BASIC is a videotape-based parent training intervention designed to improve parent-child relationships, replace harsh, negative parenting strategies with positive strategies, and reduce child conduct problems in families with young children. The validation research was conducted with parents of children aged 3-8; however, two sets of videotapes are currently available — one for parents of children aged 2-7, and one for parents of children aged 5-12. In either video series, the subjects covered include supportive play skills, positive reinforcement skills, nonviolent discipline techniques, and use of natural and logical consequences for child behavior.

The BASIC videotapes consist of over 250 brief scenes showing parents interacting with their children. When the intervention is conducted in group format, group leaders use these scenes to help teach new skills and facilitate group discussion and problem solving. Parents discuss the principles of childrearing and practice the skills through role-playing and home practice assignments.

MINIMAL IMPLEMENTATION

The intervention can be self-administered or offered for groups of 10-14 parents. The intervention generally takes 10-14 weekly, 2-hour sessions for either format.

It should be noted that any difficulties with implementation are most likely to be encountered when trying to get parents to begin the intervention. Those who do begin usually find it very interesting and useful and choose to complete most of the sessions.

Thus, it might be productive to offer some kind of incentives for beginning and/or completing the intervention (e.g., door prizes).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Researched in a series of studies with over 600 children, the BASIC intervention has been shown to be effective in significantly improving parent-child interactions and parental attitudes. Participation also decreases parents' use of spanking and reduces child conduct problems (for reviews, see Webster-Stratton, 2001; Webster-Stratton & Hancock, 1999). The effects of the intervention are consistently maintained one to three years after participation. The group discussion version has been found to be somewhat more effective and creates more consumer satisfaction than the self-administered version; however, the self-administered version is more cost-effective (Webster-Stratton, Hollingsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollingsworth, 1988).

RESOURCES REQUIRED

At least one set of Incredible Years BASIC videotapes per site (cost: $1300 for the 2-7-year-old series, $995 for the 5-12-year-old series), plus a VCR in which to play them. Other necessary resources (e.g., blackboards, group leaders) will vary depending on the format in which the intervention is to be presented. (It may be possible to obtain permission to broadcast the Incredible Years videotapes to the base community.) All necessary videos, group leader training, manuals, and handouts are available from Incredible Years. Introductory training for group leaders lasts three days. These training workshops are offered regularly in Seattle (cost: $400/person for registration, $30/person for training materials, plus travel, lodging, and meals), and certified Incredible Years trainers are also available to go on-site to train leaders if there are a minimum of 15 participants (cost: $1300/day trainer fee for 3 days, $650 half-day travel fee, plus trainer's travel, lodging, and meals, as well as $30/participant for training materials).

WHERE TO FIND MORE INFORMATION

Incredible Years
1411 8th Ave. West
Seattle, WA 98119
TOLL-FREE: (888) 506-3562
Tel: (206) 285-7565
Email: incredibleyears@seanet.com
URL: www.incredibleyears.com

Parents Who Care – Guiding Good Choices (ages 9-14)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Child Externalizing Behavior Problems (defiance, aggression)	

DESCRIPTION

Formerly known as Preparing for the Drug Free Years, Parents Who Care – Guiding Good Choices (GGC) is a multimedia training activity that promotes healthy, protective parent-child interactions (parent-child bonding and effective child management) and reduces children's risk for early substance use initiation. While GGC is presented as a substance use prevention activity, the target for direct improvement is the parent-child relationship.

Like other parenting activities, GGC helps parents set up clear expectations and rewards for positive behavior. However, this intervention does include a specific focus on the prevention of alcohol and other drug use. Through videotaped scenes, group discussion, and short lectures, group leaders teach ways for parents and children to develop a family position on drug use together. The intervention also provides opportunities for parents and children to learn and practice effective family management skills together.

MINIMAL IMPLEMENTATION

Facilitated by two co-leaders (often past participants) recruited from the community, the intervention consists of five two-hour sessions. Parents meet in groups, and their 9-14-year-old children attend one of the sessions with their parents. Given the proper equipment (e.g., large-screen video projector, public address system), GGC can be effectively conducted with large groups of parents at one time.

DOCUMENTED RESULTS (Empirical Evidence: **Best**

GGC has demonstrated significant positive effects. Participating mothers and fathers interacted more positively and less negatively with their children; they also had more emotionally satisfying parent-child relationships than did nonparticipants. These effects were maintained one year after participation (Kosterman, Hawkins, Spoth, Haggerty, & Zhu, 1997; Redmond, Spoth, Shin, & Lepper, 1999; Spoth, Redmond, & Shin, 1998). The children of intervention participants were also less likely to begin using substances (e.g., alcohol, tobacco, marijuana); those who did use such substances tended to do so less often (Spoth, Redmond, & Shin, 2001).

RESOURCES REQUIRED

VCR, overhead projector, easel & pad. All other materials and training available from the Channing Bete Company (see below). A workshop kit costs $759 plus shipping and handling; additional parent guides are also available for $7.39-$12.79 each, depending on how many are ordered. Call 1-877-896-8532 for prices on group leader training.

WHERE TO FIND MORE INFORMATION

Developer:

J. David Hawkins, Ph.D.
University of Washington
Social Development Research Group
9275 3rd Avenue NE, Suite 401
Seattle, WA 98115
Tel: (206) 685-1997
Fax: (206) 543-4507
Email: sdrg@u.washington.edu
URL: depts.washington.edu/sdrg

For information about materials and training:

Channing Bete Company
One Community Place
South Deerfield, MA 01373-0200
TOLL-FREE: (877) 896-8532
Fax: (800) 499-6464
Email: custsvcs@channing-bete.com
URL: www.channing-bete.com/positiveyouth/pages/FTC/FTC-GGC.html

Parenting Wisely (Ages 8-18)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Child Externalizing Behavior Problems (defiance, aggression)	

DESCRIPTION

Parenting Wisely (American Teen) is an interactive, video-based CD-ROM program designed to improve the parenting skills of parents of adolescents and pre-adolescents (ages 8-18). Neither previous computer experience nor the ability to read (the computer reads all text aloud) are required.

The computer program prompts parents to choose family scenarios relevant to them. Within the chosen scenario, the parents watch a challenging situation and attempt to resolve the situation by selecting from among three possible problem resolution methods. Both effective and ineffective parenting solutions are depicted for each problem, followed by comprehensive critiques and explanations of the various parenting and communication skills.

MINIMAL IMPLEMENTATION

Parenting Wisely is entirely self-administered, teaches parents how to use itself, and requires no trained staff for its delivery. It is also quite brief; although parents are able to proceed at their own pace and repeat any segment(s) as desired, most take only 2 ½-3 hours total to complete the activity.

Information is available on the factors that have contributed to successful implementation at 93 different agencies (see Gordon & Stanar, in press). For example, the program is more likely to be accessed if it is available in multiple locations within a community. Training is available to show how to generate community support for the intervention and how to add clinical components to the intervention (e.g., brief family consultation, group presentation), if desired.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Several research studies have been conducted on the intervention, and others are currently underway (for review, see Gordon, 2000; many of the reports are available online at www.familyworksinc.com). Good evidence exists that using Parenting Wisely can reduce (pre-)adolescent behavior problems, improve parenting knowledge and skills, and strengthen relationships between (pre-) adolescents and parents.

RESOURCES REQUIRED

The Parenting Wisely intervention is contained on a CD-ROM that is formatted for a personal computer (PC). The PC must have a CD-ROM player and the ability to play video on the computer screen and play sound. Technical assistance from Family Works Inc. is available at no charge. The CD-ROM costs $599, with parent workbooks costing between $6.75 and $9.00 each, depending on how many are ordered.

WHERE TO FIND MORE INFORMATION

Family Works, Inc.
20 East Circle Drive, Suite 190
Athens, Ohio 45701-3751
TOLL-FREE: (866) 234-WISE
Tel: (740) 593-9505
Fax: (541) 482-2829
Email: familyworks@familyworksinc.com
URL: www.familyworksinc.com

RETHINK

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parents' Sense of Competence ★ Inappropriate Expectations for Children's Behavior ★ Use of Corporal Punishment	★ Anger/ Hostility

DESCRIPTION

Anger Management for Parents: The RETHINK Method is a parenting intervention designed to develop anger management skills, improve parent-child interactions, and increase knowledge of child development. Anger management skills taught by the intervention include:

R - Recognize when you are beginning to feel angry, what you are angry about and what the other person might be angry about
E - Empathize with the other person
T - Think about your anger and consider if there is another way to reframe the situation
H - Hear what the other person is saying
I - Integrate compassion, respect and where appropriate, love into your responses
N - Notice how your body tells you that it is feeling angry
K - Keep to the problem at hand

RETHINK facilitators use videotapes and the Program Guide to teach the seven RETHINK skills, plus provide developmental information geared toward the ages of the children whose parents are attending. During each session, parents learn one or two of the skills and then practice them in small groups.

MINIMAL IMPLEMENTATION

The intervention consists of six weekly sessions, lasting about 2 hours each. Parents meet in groups of 10-14. The sessions are facilitated by professionals or paraprofessionals trained in the RETHINK method.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

The RETHINK method is relatively new, and only one independent study of its efficacy has been conducted so far (Fetsch, Schultz, & Wahler, 1999). After participating in the RETHINK workshops, parents generally reported experiencing less anger and feeling more in control when they were angry. They also reported using less verbal and physical aggression in dealing with their children than they had previously used. Participants also reported having more age-appropriate expectations of their children and feeling more

competent as parents following training. Since a control group was not used in this study, these results must be viewed with caution. However, the changes that were reported were all consistent with a reduction in risks for child abuse and an increase in factors that enhance family wellness.

RESOURCES REQUIRED

Materials and training are available from the Institute for Mental Health Initiative (IMHI; see below). IMHI offers a two-day training workshop for facilitators, with three half-day follow-up consultations conducted on-site. An abbreviated training is also available. Time and cost for training depends on individual need and is determined through consultation with the intervention developers.

WHERE TO FIND MORE INFORMATION

Suzanne Stutman, Co-Director
Institute for Mental Health Initiatives
2175 K Street, NW, Suite 700
Washington, DC 20037
Tel: (202) 467-2285
Fax: (202) 467-2289
Email: imhi-info@gwumc.edu
URL: www.gwumc.edu/sphhs/imhi/rethink.html

Parent-Child Relationships References

Introduction

Coleman, P. K., & Karraker, K. H. (2000). Parenting self-efficacy among mothers of school-age children: Conceptualization, measurement, and correlates. *Family Relations, 49,* 13-24.

Johnston, C., & Mash, E. J. (1989). A measure of parenting satisfaction and efficacy. *Journal of Clinical Child Psychology, 18,* 167-175.

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Triple P

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Thompson, R. W., Grow, C. R., Ruma, P. R., Daly, D. L., & Burke, R. V. (1993). Evaluation of a practical parenting program with middle- and low-income families. *Family Relations, 42,* 21-25.

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Incredible Years BASIC (Ages 3-8)

Webster-Stratton, C. (2001). The incredible years: Parents, teachers, and children training series. *Residential Treatment for Children & Youth, 18,* 31-45.

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Schaefer (Eds.), *Handbook of parent training: Parents as co-therapists for children's behavior problems* (2nd ed., pp. 98-152). New York: John Wiley & Sons.

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Parents Who Care – Guiding Good Choices (ages 9-14)

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Parenting Wisely (Ages 8-18)

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Gordon, D. A., & Stanar, C. R. (in press). Lessons learned from the dissemination of Parenting Wisely, a parent training CD-ROM. *Cognitive Behavior and Practice.*

RETHINK

Fetsch, R. J., Schultz, C. J., & Wahler, J. J. (1999). A preliminary evaluation of the Colorado RETHINK parenting and anger management program. *Child Abuse & Neglect, 23,* 353-360.

Physical Well-Being

Introduction

Many markers of physical well-being indicate an increasingly unfit country. A national survey conducted in 1999-2000 showed that an estimated 64% of U.S. adults are either overweight or obese, up from 56% in 1988-1994 (Flegal, Carroll, Ogden, & Johnson, 2002). This is perhaps not surprising, as over two-thirds of adult Americans do not exercise on a regular basis, and only 15% engage in the recommended amount of physical activity (Barnes & Schoenborn, 2003; U.S. Department of Health and Human Services, 2000). Likewise, our eating habits leave much to be desired. On average, we eat too much of the wrong kinds of food and not enough of the right kinds. For example, only one-quarter of American adults consume the recommended 5 servings a day of fruits and vegetables (Stables et al., 2002).

If we as a nation do not somehow begin to exercise more and eat properly, our health is highly likely to continue to deteriorate. In addition to its implications for weight control, regular physical activity is associated with many health benefits, including reduced risk of heart disease, stroke, high blood pressure, diabetes, colon cancer, osteoporosis, depression, and *death from any cause* (see Kahn et al., 2002). Those who exercise regularly also feel less anxious and better able to cope with their problems (Moses, Steptoe, Mathews, & Edwards, 1989). Similarly, the consumption of fruits and vegetables is related to better health, reduced risk of many major diseases — especially cancer — and possibly even a delay in the appearance of some of the signs of aging (e.g., skin wrinkles; Hyson, 2002).

Many interventions have been developed with the goal of increasing physical activity and/or fruit and vegetable intake. We present below a selection of activities that have been tested and proven effective in this regard.

Items in 2003 AF Community Assessment	Item #s
1. Healthy diet	H1g
2. Regular physical activity	H1h
3. State of physical health	H2c
4. Satisfaction with physical health	H3
5. Pregnancy	H4

Activities/Interventions
Point-of-Decision Prompts
NoonTime Walkers
5 A Day
Community Gardens

Point-of-Decision Prompts

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Physical Activity

DESCRIPTION

Point-of-decision prompts are simply signs placed near elevators and escalators that encourage people to use nearby stairs. The signs tell people about a potential health benefit from taking the stairs (e.g., weight loss) and/or remind those who want to be more physically active that taking the stairs represents an opportunity to do so.

MINIMAL IMPLEMENTATION

Signs must be created and placed.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

This intervention is simple, but can have powerful effects. Point-of-decision prompts have been tested in various locations, including shopping malls, train and bus stations, and a university library. Across several studies (e.g., Andersen, Franckowiak, Snyder, Bartlett, & Fontaine, 1998; Blamey, Mutrie, & Aitchison, 1995; see Kahn et al., 2002, for a review), posting the signs increased the use of stairs by an average of 54%. Tailoring the prompts by customizing the sign to appeal to specific populations and/or by mentioning specific benefits of stair use appeared make the activity more effective. For example, obese people were more likely to respond to a sign linking stair use to potential weight loss than to a sign listing general health benefits of taking the stairs. A message specifically designed for a black population was also especially effective.

RESOURCES REQUIRED

All that is needed are signs and people to place them in strategic locations. Sample signs created by the state of Maryland can be viewed, ordered, or printed at www.smartstepforward.org/html/stairwell.html.

WHERE TO FIND MORE INFORMATION

Gregory W. Heath, DHSc, MPH
Division of Nutrition & Physical Activity, CDC
Tel: (770) 488-5198
Email: gwh1@cdc.gov

NoonTime Walkers

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Physical Activity ★ Perceived Personal Coping ★ Anxiety

DESCRIPTION

The American College of Sports Medicine (ACSM) recommends that to produce increases in fitness and health, adults should engage in at least three 20-30 minute sessions of light to moderate physical activity (e.g., walking) each week (ACSM, 1990). The activity should be just intensive enough to raise heart rates to 60% of age-based estimated maximum (HR_{max}; Moses, Steptoe, Mathews, & Edwards, 1989). Unfortunately, it is estimated that less than 25% of the U.S. adult population exercises at this level (U.S. Department of Health and Human Services, 1991).

The NoonTime Walkers activity was designed to increase participants' physical activity to the recommended level. In order to meet this goal, the intervention utilizes a combination of frequent prompting, self-monitoring, and social support.

MINIMAL IMPLEMENTATION

Participants attend an initial 15-minute training session at which they receive: (a) area walking maps detailing various walking routes with distances noted, (b) handouts on how to enlist a walking partner or begin a walking group, (c) an age-based table of maximum heart rates, and (d) basic strategies for starting (i.e., start slowly and work it into your daily routine). Each participant is also given the goal to walk with at least one partner for at least 20 minutes at least three times each week. For the next three months (or longer, if desired), each participant receives a weekly one-minute telephone call asking simply, "How's your walking activity going?" If the participant has walked, the caller is supportive of the amount of walking accomplished; if the participant has not walked, the caller is supportive of future attempts.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

In the study assessing the intervention's effectiveness (Lombard, Lombard, & Winett, 1995), women were much more likely to participate than men. The simple procedures involved were surprisingly effective at getting the participants to engage in and maintain a regular exercise activity. Of those who received the intervention as described above, 63% were still walking 3 months after the phone calls stopped. Of these walkers, 82% were still meeting the ACSM recommendations of at least 3 exercise sessions a week lasting at least 20 minutes each. These results were as good as those for participants who received highly structured telephone calls, and much better than those who received less

frequent calls or no calls at all. The authors hypothesized that the phone calls helped people to form a walking habit, which they were able to maintain on their own once the calls ceased.

Those who engage in the intervention and meet the ACSM minimum recommendations are likely to see tremendous benefits. In one particularly well-designed study (Moses, Steptoe, Mathews, & Edwards, 1989), it was shown that 10 weeks of moderate aerobic activity (at 60% HR_{max}) significantly increased participants' perceived and actual level of fitness, decreased their anxiety, and improved their perceived coping ability. Ten weeks of high-level aerobic exercise (at 70-75% HR_{max}) increased physical fitness somewhat more than did moderate exercise, but had no effect on either anxiety or perceived coping.

RESOURCES REQUIRED

Handouts, plus someone to conduct the initial training session and to make the weekly telephone calls are the only required resources. Handouts are available from the intervention developer or the Weight-control Information Network (see below); for an age-based maximum heart rate table, go to www.health.co.delaware.oh.us/dawg.htm.

WHERE TO FIND MORE INFORMATION

Intervention developer:

David N. Lombard, Ph.D.
3242 Mallard Cove La.
Fort Wayne, IN 46804-2883
Tel: (260) 459-2900
Email: drlombard@comcast.net

Or contact:

Weight-control Information Network
1 Win Way
Bethesda, MD 20892-3665
TOLL-FREE: (877) 946-4627
Tel: (202) 828-1025
Fax: (202) 828-1028
Email: win@info.niddk.nih.gov
URL: www.niddk.nih.gov/health/nutrit/walking/walkingbro/walking2.html

5 A Day

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Healthy Diet

DESCRIPTION

The 5 A Day for Better Health Program is a joint effort of the National Cancer Institute, the Produce for Better Health Foundation, plus numerous other governmental, nonprofit, and corporate-sponsored organizations. Its message to Americans is simple: Eat 5 or more servings of fruits and vegetables every day for better health.

Since 1991, states, communities, and organizations have utilized virtually every channel imaginable to distribute this message (Havas et al., 1995), including:

- Mass media (e.g., television, radio, magazine and newspaper articles)
- Schools (e.g., changes in food service environment, workshops, classroom curricula)
- Community centers (e.g., periodic mailings, festivals)
- Churches (e.g., nutrition messages, contests and demonstrations, planting fruit trees and vegetable gardens)
- Worksites (e.g., lectures, special events, taste testing, discussion groups, contests, information distribution via brochures, videos, posters in cafeterias, etc.)
- WIC sites (e.g., written materials, visual reminders)
- Families (e.g., written learn-at-home programs for families; having children contribute illustrated recipes of foods containing fruits and vegetables, which are compiled into a cookbook and distributed)
- Point-of-purchase bulletins (e.g., signs in supermarkets)

MINIMAL IMPLEMENTATION

Due to the variety of ways in which this program can be implemented, it is virtually impossible to define a "minimum." However, placing one poster extolling the virtues of fruit and vegetable consumption would not be considered sufficient. Please contact the Air Force program coordinator (see below) to determine what methods are likely to be most practical and effective for your base.

DOCUMENTED RESULTS (Empirical Evidence: **Best**

Virtually all of the evidence collected since the program began in 1991 has demonstrated that it has improved public awareness of the health benefits of eating fruits and vegetables, and has significantly increased program recipients' daily fruit and vegetable consumption (for a review, see National Cancer Institute, 2001). In general, the more intensively the program is implemented, the stronger the effects. For example, one study (Sorensen et al., 1999) found that a series of interventions involving worksites and

families increased fruit and vegetable intake by almost three times as much as did the worksite interventions alone.

RESOURCES REQUIRED

Specific resources will vary greatly depending on the ways in which the program is to be implemented. Many materials (e.g., program tips, media packages, recipes) are available free of charge through the National Cancer Institute's 5 A Day website (see below).

WHERE TO FIND MORE INFORMATION

National Cancer Institute
URL: www.5aday.gov

Air Force 5 A Day Coordinators:

Maureen Harback, Major, USAFR, BSC
Chief, Community Nutrition
AFMOA/SGZP
110 Luke Ave, Room 405
Bolling AFB, DC 20332-7050
Tel: (202) 767-4264
Fax: (202) 404-8089
Email: maureen.harback@pentagon.af.mil

Community Gardens (see page 13)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Unity ★ Support from Neighbors			★ Healthy Diet ★ Perceived Personal Coping

Physical Well-Being References

Introduction

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Point of Decision Prompts

Anderson, R. E., Franckowiak, S. C, Snyder, J., Bartlett, S. J., & Fontaine, K. R. (1998). Can inexpensive signs encourage the use of stairs? Results from a community intervention. *Annals of Internal Medicine, 129,* 363-369.

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NoonTime Walkers

Lombard, D. N., Lombard, T. N., and Winett, R. A. (1995). Walking to meet health guidelines: The effect of prompting frequency and prompt structure. *Health Psychology,* 2, 164-170.

Moses, J., Steptoe, A., Mathews, A., & Edwards, S. (1989). The effects of exercise training on mental well-being in the normal population: A controlled trial. *Journal of Psychosomatic Research, 33,* 47-61.

5 A Day

Havas, S., Heimendinger, J., Damron, D., Nicklas, T. A., Cowan, A., Beresford, S. A. A., et al. (1995). 5-a-day for better health — 9 community research projects to increase fruit and vegetable consumption. Public Health Reports, 110, 68-79.

National Cancer Institute. (2001). *5 A Day for Better Health Program monograph.* Retrieved September 12, 2003, from http://www.5aday.gov/pdf/masimaxmonograph.pdf

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Financial Stress

Introduction

Financial stress is an extremely widespread problem among American families today. Our society tends to measure financial success not by how much wealth we accumulate, but rather by how much we spend and what we own (Kottler, 1999). Consumer debt levels continue to rise, already-low personal saving rates are in further decline, and household "debt-service burden" — the proportion of disposable income that must be used to make minimum scheduled payments on mortgage and consumer debt — is at near-record levels (Braunstein & Welch, 2002). Perhaps not surprisingly, over 1.5 million Americans filed for personal bankruptcy *in 2002 alone,* more than triple the almost one-half million who filed in 1987 (American Bankruptcy Institute, n.d.).

Understandably, financial difficulties can be a major stressor, wreaking havoc on individuals' mental health and marital relationships. Personal financial problems have also been linked with reduced employee productivity (Joo & Grable, 2000). It has been conservatively estimated that 15% of all employees in the United States are experiencing stress from poor personal financial situations and behaviors to the extent that it negatively affect the ability to do their jobs — and the proportion may be as high as 40% or 50% in some organizations (Garman, Leech, & Grable, 1996).

In light of all of this, many employers have begun offering financial education and/or services (e.g., retirement planning, debt counseling) to their employees, and the employees appreciate it. Indeed, up to 85% of all employees want to get financial information where they work (Gorbach, 1997). In general, workplace financial education has great potential (Employee Benefits Research Institute, 1998); however, there are many different types of education and services that can be offered, and few have been empirically evaluated. The interventions described in this chapter, in contrast, have been tested and shown to effectively improve people's financial behaviors.

Items in 2003 AF Community Assessment	Item #s
1. Not earning enough to meet needs	J1, J2, J3
2. Find it difficult to pay bills due to lack of money	J1, J2
3. Bounced checks	J2
4. Missed payments/made payments late	J2
5. Been contacted by bill collector	J2
6. Had something repossessed or utilities shut off	J2
7. Declared bankruptcy	J2

Activities/Interventions
EDSA Group© Workshops
Self-Control Training

EDSA Group Workshops

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Financial Stress

DESCRIPTION

The EDSA Group is a Louisiana-based financial education company that specializes in teaching people to make informed decisions about their personal finances and employer-sponsored benefit plans. Many such companies exist; however, unlike most, the EDSA Group's workshops have been empirically validated. Several workshops are available; the workshops offered to participants in the validation study were as follows:

- *Money Basics,* focusing on comprehensive financial planning topics.
- *Retiring Easy,* a pre-retirement workshop for those who are 5 to 15 years away from retirement.
- *Magic of 401(k),* which teaches employees how to use their retirement plans to effectively meet retirement income needs.
- *Planning Plus,* one-on-one counseling at the employer's site that allows personalized consultation for those who have attended a company-sponsored workshop.

MINIMAL IMPLEMENTATION

EDSA Group workshops vary in length — *Money Basics* lasts for 6 hours, *Retiring Easy* takes 3 hours to present, and *Magic of 401(k)* is a 2-hour course.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

Several of the most well-known researchers in the field of workplace financial education conducted a study of the effects of EDSA Group workshops at a Southeastern chemical production plant where the workshops had been offered repeatedly over the course of three years (Garman, Kim, Kratzer, Brunson, & Joo, 1999). About half of those participating in the study had attended at least one workshop with most of attending only one or two of the workshops offered, with *Money Basics* being the most popular course.

When compared to nonparticipants, workshop participants reported that they (a) had greater satisfaction with the amount of money they were able to save, (b) felt more confident in their ability to save for a comfortable retirement, (c) were more likely to set money aside for savings, and (d) were more likely to set money away for retirement. In contrast, compared to participants, nonparticipants were more likely to (a) be worried about being able to pay monthly expenses, (b) be worried about the amount of money they owed, (c) have had to cut living expenses, and (d) have reached the maximum limit on a credit card. Workshop participants reported having made several positive changes in their personal financial behavior as a result of the information they had received.

The results of this study must be interpreted with some caution, as participation was voluntary, and those with poorer financial habits may have elected not to participate. However, by far the most common reason given for nonparticipation was "the time conflicted with my schedule." Also, the opportunity to attend more financial education workshops was desired by 80% of participants and nonparticipants alike.

RESOURCES REQUIRED

A room in which to conduct the workshops is needed, along with someone who has been trained to present them. The EDSA Group offers a nationwide network of rigorously trained financial professionals plus traveling instructors; their fees vary depending on location and what services are to be provided. Alternatively, base staff can be trained to provide workshops utilizing EDSA Group curricula. Again, fees will vary depending on the nature and amount of training to be provided.

WHERE TO FIND MORE INFORMATION

The EDSA Group, Inc.
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8280 YMCA Plaza Drive, #4
Baton Rouge, LA 70810
TOLL-FREE: (800) 942-2777
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Email: info@theedsagroup.com
URL: www.theedsagroup.com

Self-Control Training

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Financial Stress

DESCRIPTION

Whereas the EDSA Group workshops described above primarily target saving and investing, self-control training involves learning to reward oneself for changing a bad habit — in this case, inefficient, impulsive spending.

MINIMAL IMPLEMENTATION

Participants meet in small groups for one hour per week over a 4-week period. Two weeks prior to the first meeting, they are informed that for the next 6 weeks, they will be required to turn in comprehensive weekly spending reports. These reports should be user-friendly forms that include daily totals for money spent on housing, food, transportation, clothing, personal care (e.g., cosmetics, haircuts), medical care, recreation, and an "other" category (e.g., insurance, gifts, charitable donations, savings). The forms should also include space for recording income before taxes, as well as balances on savings and checking accounts and credit cards.

At the first weekly meeting, the participants learn the basic principles that make the intervention work. They are taught that they will be rewarding themselves for behaving in ways that interfere with bad spending habits. Each person then compiles a list of possible rewards (e.g., soda, watching television) and a list of self-defeating financial habits (e.g., excessive use of credit cards, borrowing money from friends, impulsive spending). Finally, each participant chooses one specific habit to work on during the following week (e.g., not going downtown or to the mall without a specific purpose in mind). It is emphasized that they should set realistic goals and not expect extraordinary results immediately. They are instructed to use self-praising thoughts (e.g., "I am so in control") as well as tangible rewards from their list whenever they engage in an activity that competes with unnecessary or impulsive spending.

At the second meeting, each participant's progress is discussed, and the importance of breaking self-defeating chains of behavior as early as possible is emphasized. Further suggestions are made, including destroying credit cards, making and keeping to a budget, and avoiding carrying either credit cards or a checkbook when going anywhere. Participants choose a second self-defeating behavior as the target for the week.

The third meeting again involves a discussion of progress and further suggestions, including carrying only small amounts of money when going out, making shopping lists and sticking to them, taking only enough money to purchase what was on the list,

keeping cash at home in labeled envelopes for specific purposes (e.g., clothing, entertainment), not borrowing money unless absolutely necessary, and setting up a priority list of items or events toward which participants would like to save (e.g., clothes, travel, camera).

At the fourth meeting, everyone reviews and comments on the progress they have made. In addition to practicing the self-control techniques they have already learned, participants are encouraged to open a bank account, with any interest earned spent however they wish. It is also suggested that they try to perform various tasks that they would ordinarily pay someone else to do (e.g., changing the oil in their own car, packing their lunch rather than buying it) and depositing the money saved in this way directly into their bank account.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

This intervention was originally designed and tested over 25 years ago (Paulsen, Rimm, Woodburn, & Rimm, 1977). All participants in the validation study saw themselves as overspenders, and were assigned to attend either a self-control training group as outlined above, or a group that met for four weeks and simply discussed financial problems. Participants in the self-control group reported reducing their discretionary spending, on average, by a whopping *55%* over the course of the 4 weeks, while those who attended the discussion group were spending slightly more than they had before attending. The effects of self-control training were still present 3 months following participation.

RESOURCES REQUIRED

Necessary resources include forms that can be used to track spending, a place in which to meet, and someone to lead and instruct the group.

WHERE TO FIND MORE INFORMATION

N/A

Financial Stress References

Introduction

American Bankruptcy Institute. (n.d.) *U.S. Bankruptcy Filings 1980-2002.* Retrieved September 1, 2003, from http://www.abiworld.org/stats/1980annual.html.

Braunstein, S., & Welch, C. (2002). Financial literacy: An overview of practice, research, and policy. *Federal Reserve Bulletin, 88,* 445-458.

Employee Benefit Research Institute. (1998). *Summary of findings: 1998 RetirementConfidence Survey.* Retrieved August 26, 2003, from http://www.ebri.org/rcs/1998/RCS.htm.

Garman, E. T., Leech, I. E., & Grable, J. E. (1996). The negative impact of employee poor personal financial behaviors on employers. *Financial Counseling and Planning, 7,* 157-168.

Gorbach, T. R. (1997). A case for comprehensive financial education in the workplace. *Personal Finances and Worker Productivity, 1,* 66-70.

Joo, S., & Grable, J. E. (2000). Improving employee productivity: The role of financial counseling and education. *Journal of Employment Counseling, 37,* 2-15.

Kottler, J. A. (1999). *Exploring and treating acquisitive desire: Living in the material world.* Thousand Oaks, CA: SAGE.

EDSA Group Workshops

Garman, E. T., Kim, J., Kratzer, C. Y., Brunson, B. H., & Joo, S. (1999). Workplace financial education improves personal financial wellness. *Financial Counseling and Planning, 10,* 79-88.

Self-Control Training

Paulsen, K., Rimm, D. C., Woodburn, L. T., & Rimm, S. A. (1977). A self-control approach to inefficient spending. *Journal of Consulting and Clinical Psychology, 45,* 433-435.

Perceived Personal Coping Ability

Introduction

Stress is a part of everyone's life. Stress is unavoidable, as it is our adaptation to changes in our environments. Stress can have positive effects — for example, it can make life more exciting and interesting and force us to be creative problem-solvers. On the other hand, stress can have extremely negative effects on physical and mental well-being — for example, it can lead to tension and anxiety, depression, interpersonal problems, and hypertension (see Machacova, 1999). In addition, stress and the inability to cope with it are risk factors for domestic violence, substance abuse, and suicide (Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001; Sinha, 2001; Yufit & Bongar, 1992).

The interventions listed in this section have all been shown to significantly increase people's perceptions that their lives are going well, that they are able to cope with the stressors they face. The methods vary from direct instruction in coping skills to aerobic exercise, and all of the interventions also influence other NORTH STAR-targeted risk factors.

Items in 2003 AF Community Assessment	Item #s
1. Successfully copes with stress	H1b
2. Maintains positive relationships	H1d, F1
3. Willing to ask for help with a major problem	H1f
4. Satisfied with emotional well-being	H2a
5. Satisfied with life as a whole	H2b
6. Successfully manages family and work demands	M4

Activities/Interventions
Stress and the Healthy Mind
Unstress
NoonTime Walkers
Triple P
Couples Coping Enhancement Training (CCET)
Community Gardens

Stress and the Healthy Mind

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Perceived Personal Coping ★ Depression ★ Anger/Hostility ★ Anxiety ★ Self-Esteem

DESCRIPTION

Stress and the Healthy Mind (HLTH 486) is a college course that has been taught at the University of Maryland since 1990. As implied by the course title, it was designed to improve overall mental health and decrease the impact of stress on the participants.

During the course, the instructor outlines life characteristics and habits that are likely lead to mental health versus mental illness. Each participant is assigned to come up with, implement, and monitor a sensible sleeping, eating, and exercising plan. Skills to prevent depression and problematic anger, reduce anxiety and worry, and increase self-esteem are taught and practiced in class and at home.

MINIMAL IMPLEMENTATION

At the University of Maryland, the course meets twice weekly, ninety minutes each session, for fifteen weeks. The number of participants in a class is generally limited to fewer than fifteen, so as to promote discussion, skill practice, and teamwork.

This course could be taught on-base as part of AD members' training or offered to the general base community. Bryant (2000) has also suggested that an organization such as the FBI or the military might form mutually beneficial alliances with local colleges, which could offer stress-reduction courses such as this one to the employees and/or families of the organization.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

Participation in the course has been found to significantly reduce depression, anxiety, and hostility, and to significantly increase the participants' self-esteem (Brown, 2002; Schiraldi & Brown, 2001; 2002). The effects were maintained at least one month after completing the course.

RESOURCES REQUIRED

A course outline and a list of readings and other needed materials are available from the course's developer (see below).

WHERE TO FIND MORE INFORMATION

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2387 HHP Building, Valley Drive
College Park, MD 20742
Tel: (301) 405-2518
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Unstress

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Perceived Personal Coping ★ Anxiety

DESCRIPTION

In the late 1980s, a team of New Zealand researchers noticed that there were no widely available, relatively low-cost, community-based interventions for stress management (unlike, say, Weight Watchers for weight control). They decided to work with members of their community to create one. The result was "Unstress."

Unstress participants meet in groups to discuss principles and skills related to successfully coping with stress; topics include prioritizing, time management, goal setting, decision making, assertiveness, and relaxation, among others. "Homework" is assigned in each session, and personal progress is reported on the next week.

MINIMAL IMPLEMENTATION

Groups of 6-9 participants hold weekly meetings for 10 weeks; each sessions lasts about 90 minutes. The first Unstress groups in a given area are run by professionals from the organization that is implementing the intervention; successful "graduates" of the intervention are then recruited and trained to lead future groups. (Other than starting discussions and helping to set up groups, group leaders act as participants rather than "experts.")

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

Participation in the Unstress intervention has been shown to significantly reduce tension and anxiety, while increasing the perceived ability to cope and a general sense of well-being (Raeburn, Atkinson, Dubignon, McPherson, & Elkind, 1993). Ninety percent of the participants rated the course positively, and even one year after their groups finished meeting, over 80% reported that overall, having participated in Unstress was still helping them to cope.

RESOURCES REQUIRED

Professional involvement is kept to a minimum, printed materials are bulk photocopied, and the only other necessary resources are blank audiocassette tapes and locations in which the groups can meet; thus, the Unstress intervention is extremely low-cost. In 1993, it was estimated that running a group cost roughly US$12 per participant ($1.20/session), plus US$12 per session to pay the lay group leader. Training materials, handouts, relaxation tapes are available from Dr. John Raeburn (see below).

WHERE TO FIND MORE INFORMATION

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NoonTime Walkers (see page 66)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Physical Activity ★ Perceived Personal Coping ★ Anxiety

Triple P (see page 49)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Marital/Romantic Relationships ★ Perceived Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depression (Levels 4 & 5 only) ★ Perceived Personal Coping ★ Anxiety (Levels 4 & 5 only)

Couples Coping Enhancement Training (CCET) (see page 36)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Marital/Romantic Relationships ★ Perceived Family Coping	★ Perceived Personal Coping

Community Gardens (see page 13)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Unity ★ Support from Neighbors			★ Healthy Diet ★ Perceived Personal Coping

Perceived Personal Coping Ability References

Introduction

Machacova, H. (1999). *Behavioural prevention of stress.* Prague, Czech Republic: Charles University.

Schumacher, J. A., Feldbau-Kohn, S., Slep, A. M. S., & Heyman, R. E. (2001). Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behavior, 6,* 281-352.

Sinha, R. (2001). How does stress increase risk of drug abuse and relapse? *Psychopharmacology, 158,* 343-359.

Yufit, R. I., & Bongar, B. (1992). Suicide, stress, and coping with life cycle events. In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 553-573). New York: Guilford.

Stress and the Healthy Mind

Brown, S. L. (2002). Teaching preventive mental health skills to functional college students: A comparison of three classroom-based interventions. *Dissertation Abstracts International, 62*(9), 3966B.

Bryant, H. E. (2000). Stress factors and stress management strategies for FBI agent spouses: Basis for potential community college workshops and classes. *Dissertation Abstracts International, 60*(7), 2692A.

Schiraldi, G. R., & Brown, S. L. (2001). Primary prevention for mental health: Results of an exploratory cognitive-behavioral college course. *Journal of Primary Prevention, 22,* 55-67.

Schiraldi, G. R., & Brown, S. L. (2002). Preventive mental health education for functioning adults: Stress, coping and mental health courses at the University of Maryland. *International Journal of Emergency Mental Health, 4,* 57-64.

Unstress

Raeburn, J. M., Atkinson, J. M., Dubignon, J. M., Mcpherson, M., & Elkind, G. S. (1993). "Unstress": A low-cost community psychology approach to stress-management: An evaluated case study from New Zealand. *Journal of Community Psychology, 21,* 113-123.

Anger

Introduction

Almost everyone gets angry now and then; anger is a natural emotional response to frustrating situations. However, excessive or uncontrolled anger can have a negative impact on enjoyment of life, personal relationships, and physical health (Del Vecchio and O'Leary, in press). It can lead to problems in the workplace (Glomb, 2002) and/or dangerous driving behaviors (Deffenbacher, Huff, Lynch, Oetting, and Salvatore, 2000.

Over the past 25 years, several effective techniques for managing anger have been developed. The interventions listed in this section have all been shown to either improve people's perception that their anger is under control or to decrease aggressive behavior and increase prosocial behavior. Attitudes toward violence and aggression are also addressed in this section in the form of a intervention that teaches people not to think of aggression as a way to handle problems.

Activities/Interventions
Cognitive-Relaxation Coping Skills
RETHINK
Stress and the Healthy Mind
Changing the Sexual Aggression-Supportive Attitudes of Men

Cognitive Relaxation Coping Skills (CRCS)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Anger/ Hostility

DESCRIPTION

Cognitive Relaxation Coping Skills (CRCS) is a combination of two common methods used for helping people manage their anger: cognitive coping skills and relaxation training (Deffenbacher & Stark, 1992). During the first two sessions, a rationale for the intervention is introduced and participants are trained in various relaxation techniques. In Session 3, the group focuses on changing thoughts that lead to and maintain anger. Sessions 4-8 involve the application of cognitive and relaxation coping strategies to a variety of anger-inducing situations. Homework is assigned each week and involves practicing the skills that were taught in each session.

MINIMAL IMPLEMENTATION

Groups of 9-11 participants hold weekly meetings for 8 weeks; each sessions lasts about 60 minutes. The groups are run by professionals who follow a published treatment manual (Deffenbacher & McKay, 2000b).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

CRCS has been used extensively with college students who identify themselves as having "high anger," and has also been shown to be effective for angry drivers (Deffenbacher, Huff, Lynch, Oetting, & Salvatore, 2000) and for adolescents with high levels of anger (Deffenbacher, Lynch, Oetting & Kemper, 1996). In a series of excellent studies, Deffenbacher and his colleagues have demonstrated that CRCS can effectively reduce participants' anger both in the short term and 12 to 15 months following intervention participation (Deffenbacher, 1988; Deffenbacher, Oetting, Huff, & Thwaites, 1995; Deffenbacher, Thwaites, Wallace, & Oetting, 1994).

RESOURCES REQUIRED

Professional facilitation of the meetings is required. A training manual for facilitators and a user's manual for participants are available (Deffenbacher & McKay, 2000a; 2000b). The only other resource needed is a location in which the groups can meet.

WHERE TO FIND MORE INFORMATION

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Email: jld6871@lamar.colostate.edu
URL: psyweb.psych.colostate.edu/psylist/detail.asp?Num=14

Changing the Sexual Aggression-Supportive Attitudes of Men: A Psychoeducational Intervention

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Approval of Aggression

DESCRIPTION

This one-hour presentation consists of arguments in favor of rejecting interpersonal violence, rape myths, adversarial sexual beliefs, and male dominance. Participants watch the presenters role-play vignettes. Presenters then discuss the negative consequences of accepting interpersonal violence, rape myths, adversarial sexual beliefs, and male-dominance ideology. They also discuss the social consequences of accepting these beliefs. After the presentation, participants are encouraged to discuss their thoughts with the presenters.

MINIMAL IMPLEMENTATION

This presentation requires two people who are trained in role-playing vignettes and facilitating discussion. The presentation takes about 1 hour and can be given to a large group.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Attitudes toward interpersonal violence, adversarial sexual beliefs, acceptance of rape myths, and sex role stereotyping were measured just prior to and after the presentation. Compared to those of nonparticipants, attitudes of participants changed significantly. A one-month follow-up indicated that participants in the presentation were more willing to listen to a telephone solicitor who was seeking volunteers for a women's safety project (Gilbert, Heesacker, & Gannon, 1991). The researchers interpreted this to mean that the self-reported attitude changes had generalized to a more naturalistic situation. No attempts to replicate this study have been reported in the literature; however, similar presentations have also been found to be effective in altering men's attitudes towards violence toward women (O'Neal & Dorn, 1998).

RESOURCES REQUIRED

Copies of a sample transcript of the presentation, as well as other materials, can be obtained from Dr. Martin Heesacker (see below). The only other resource required is a room in which the presentation can be offered.

WHERE TO FIND MORE INFORMATION

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URL: www.psych.ufl.edu/~heesacker/

Stress and the Healthy Mind (see page 80)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Perceived Personal Coping ★ Depression ★ Anger/Hostility ★ Anxiety ★ Self-Esteem

RETHINK (see page 60)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parents' Sense of Competence ★ Inappropriate Expectations for Children's Behavior ★ Use of Corporal Punishment	★ Anger/ Hostility

Anger References

Introduction

Deffenbacher, J. L., Huff, M. E., Lynch, R. S., Oetting, E. R., & Salvatore, N. F. (2000). Characteristics and treatment of high-anger drivers. *Journal of Counseling Psychology, 47,* 5-17.

Del Vecchio, T., & O'Leary, K. D. (in press). Effectiveness of anger treatments for specific anger problems: A meta-analytic review. *Clinical Psychology Review.*

Glomb, T. M. (2002). Workplace anger and aggression: Informing conceptual models with data from specific encounters. *Journal of Occupational Health Psychology, 7,* 20-36 .

Cognitive Relaxation Coping Skills (CRCS)

Deffenbacher, J. L. (1988). Cognitive-relaxation and social skills treatments of anger: A year later. *Journal of Counseling Psychology, 35,* 234-236.

Deffenbacher, J. L., Huff, M. E., Lynch, R. S., Oetting, E. R., & Salvatore, N. F. (2000). Characteristics and treatment of high-anger drivers. *Journal of Counseling Psychology, 47,* 5-17.

Deffenbacher, J. L., Lynch, R. S., Oetting, E. R., & Kemper, C. C. (1996). Anger reduction in early adolescents. *Journal of Counseling Psychology, 43,* 149-157.

Deffenbacher, J. L., and McKay, M (2000a). *Overcoming situational and general anger.* Oakland, CA: New Harbinger.

Deffenbacher, J. L., and McKay, M (2000b). *Overcoming situational and general anger: A protocol for the treatment of anger based on relaxation, cognitive restructuring, and coping skills training.* Oakland, CA: New Harbinger.

Deffenbacher, J. L, Oetting, E. R., Huff, M. E., & Thwaites, G. A. (1995). Fifteen-month follow-up of social skills and cognitive-relaxation approaches to general anger reduction. *Journal of Counseling Psychology, 42,* 400-405.

Deffenbacher, J. L., & Stark, R. S. (1992). Relaxation and cognitive-relaxation treatments of general anger. *Journal of Counseling Psychology, 39,* 158-167.

Deffenbacher, J. L., Thwaites, G. A., Wallace, T. L., & Oetting, E.R. (1994). Social skills and cognitive-relaxation approaches to general anger reduction. *Journal of Counseling Psychology, 41,* 386-396.

Changing the Sexual Aggression-Supportive Attitudes of Men: A Psychoeducational Intervention

Gilbert, B.J., Heesacker, M., & Gannon, L.J. (1991). Changing the sexual aggression-supportive attitudes of men: A psychoeducational intervention. *Journal of Counseling Psychology, 38,* 197-203.

O'Neal, M. F., &Dorn, P.W. (1998). Effects of time and an educational presentation on student attitudes toward wife-beating. *Violence and Victims, 13,* 149-157.

Depression

Introduction

Depression is a debilitating and relatively common problem. The World Health Organization has identified major depression as the fourth leading cause of disability worldwide, and projects that it will be the second leading cause by 2020 (Murray & Lopez, 1996). In the U.S. it is estimated that over 17% of all people in the U.S. will suffer from clinical depression at some point during their lives (Kessler et al., 1994), and that at any given point in time, roughly 5% of the adult population is clinically depressed (Blazer, Kessler, McGonagle, & Swartz, 1994). Subclinical levels of depressive symptoms are even more common, as well as predictive of increased mortality and a fourfold risk increase for a major depressive episode (Cuijpers & Smit, 2002; Horwath, Johnson, Lerman, & Weissman, 1994).

Treatment for depression typically takes place either via one-on-one professional contact (i.e., individual psychotherapy and/or prescription of antidepressant medication) or via group therapy. However, in a given year, only about one in five individuals who have a psychiatric disorder like depression will seek professional help (Kessler et al., 1994), and subclinical depression often goes unrecognized — by both the depressed individual and the health care system — and therefore untreated.

The interventions listed in this section have been shown to significantly reduce depressive symptoms. One, *Feeling Good*, targets depression specifically and exclusively. The other interventions also address other risk factors targeted by NORTH STAR, such as Parent-Child Relationships and/or Perceived Personal Coping.

Items in 2003 AF Community Assessment	Item #s
1. Can't get going	H5a
2. Sad	H5b
3. Can't sleep	H5c
4. Everything feels like an effort	H5d
5. Lonely	H5e
6. Can't shake the blues	H5f
7. Can't concentrate	H5g

Activities/Interventions
Feeling Good
Cognitive Appraisal Program
Triple P (Levels 4 & 5 only)
Stress and the Healthy Mind

Feeling Good

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Depression

DESCRIPTION

Negative thoughts and beliefs (e.g., "I'm worthless," "It's all hopeless," "I can't ever do anything right," "I hate myself") can often lead to and/or accompany depressive symptoms. Dr. David Burns wrote *Feeling Good*, a self-help classic originally published in 1980, to enable readers to combat these thoughts and thereby reduce their depression.

Written at about a 6th-grade reading level (Scogin, Jamison, & Gochneaur, 1989), the book has recently been revised and updated (Burns, 1998). This latest version is 706 pages long, available in paperback, and relatively inexpensive. It contains a self-administered test so that readers can gauge how depressed they are. Most chapters also contain exercises for readers to complete; these exercises are similar to those that would be assigned by a cognitive psychotherapist.

MINIMAL IMPLEMENTATION

A main advantage of the *Feeling Good* intervention is that it is self-administered. Of course, in order for individuals to be considered "treated," they must read at least some of the book. As a general guideline, participants in the Jamison & Scogin (1995) study reported having read between 23% and 100% of the book (average 83%). If desired, a quiz is available that reliably distinguishes between those who have read the book and those who have not (Scogin, Jamison, Floyd, & Chaplin, 1998). It may be critical to inform intervention participants in advance that they will receive a book to read, not traditional psychotherapy (Scogin, Floyd, Jamison, Ackerson, Landreville, & Bissonnette, 1996).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Mildly-to-moderately-depressed adults who read *Feeling Good* over a 1-month period reported decreases in depressive symptoms, frequency of negative thoughts, and dysfunctional attitudes (Jamison & Scogin, 1995). Seventy percent of those who read the book no longer met criteria for major depression, while only 3% of controls were no longer clinically depressed. Later, after they had also read the book, 73% of controls did not meet clinical depression criteria. Treatment gains were maintained at 3-year follow-up (Smith, Floyd, Scogin, & Jamison, 1997).

RESOURCES REQUIRED

One copy of *Feeling Good* is required per individual/family to be treated. (Purchases of 50 books or more receive a discount of 40-45% from the publisher.) In the validation studies, participants received weekly phone calls for assessment purposes and to answer

any questions (e.g., "What does the book mean when it says. . .?", "How many pages am I supposed to read this week?"). We recommend that the phone number and email address of a intervention contact person (e.g., someone from Life Skills) be provided inside the front cover of the book. The contact person should be someone who is familiar with the book and its concepts and could answer questions. In addition, calling individuals/families who have received the book to see how their reading is progressing and answer any questions may be a good way to increase the reading rate.

WHERE TO FIND MORE INFORMATION

For information about bulk purchases, contact:

Special Markets Department
HarperCollins Publishers, Inc.
10 East 53rd Street
New York, NY 10022-5299
Tel: (212) 207-7528
Fax: (212) 207-7222

Cognitive Appraisal Program (see page 47)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Special Needs of Child(ren)	★ Depressive Symptomatology

Triple P (Ages birth-12) (see page 49)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Marital/Romantic Relationships ★ Perceived Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depression (Levels 4 & 5 only) ★ Perceived Personal Coping ★ Anxiety (Levels 4 & 5 only)

Stress and the Healthy Mind (see page 80)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Perceived Personal Coping ★ Depression ★ Anger/Hostility ★ Anxiety ★ Self-Esteem

Depression References

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Thoughts and Beliefs about Alcohol and Drugs

Introduction

People vary widely in what they think and believe about the use and effects of alcohol and other drugs. Many of these substance-related thoughts and beliefs are related to people's substance use and abuse patterns, and have been effectively targeted by prevention activities. Examples relevant to NORTH STAR are included here.

"Alcohol expectancies" are the outcomes — positive or negative — that are expected to result from the consumption of alcohol. These expectancies are strongly related to the amount of alcohol people choose to consume and their risk for alcohol abuse (Jones, Corbin, & Fromme, 2001; Kilbey, Downey, & Breslau, 1998). For example, those who expect that having a few drinks will make them "the life of the party" or improve their sexual performance tend to consume more alcohol. On the other hand, those who expect that drinking — or drinking too much — will lead to a hangover, impair their sexual performance, or make them appear stupid tend to restrain their drinking behavior.

In the workplace, in addition to having inaccurate beliefs regarding drug and alcohol usage among their peers, civilians may also lack knowledge regarding their organization's drug and alcohol policies and Employee Assistance Program (EAP). This may lead them to distrust EAP confidentiality and/or to stigmatize help-seeking (Beidel, 1999). (Similar issues may affect the Air Force's Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program.) Trust/confidentiality issues are thought to be the main reasons why workers often fail to seek help for drug or alcohol problems in themselves or their colleagues.

The interventions described below have been designed to beneficially affect people's thoughts and beliefs about substance use, and thereby to reduce substance consumption.

Activities/Interventions
Alcohol Expectancy Challenge
Team Awareness

Alcohol Expectancy Challenge

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Alcohol Expectancies

DESCRIPTION

The Alcohol Expectancy Challenge is a brief, inexpensive procedure designed to reduce the expectation that consuming alcohol has noticeable positive effects.

Challenge participants attend sessions in which they consume either (a) an alcoholic beverage or (b) a placebo (e.g., a glass of tonic with a drop of vodka rubbed across the glass rim to make the drink smell and taste of alcohol despite containing none). After participating in group activities, they are asked to use behavioral cues to identify those individuals in the group — including themselves — who had or had not consumed alcohol. The identification errors that are made are used to challenge alcohol expectancies. Between sessions, participants are asked to monitor the alcohol expectancies that are communicated to them (e.g., peers, media); these observations are discussed in the sessions.

MINIMAL IMPLEMENTATION

Groups of 10 to 15 participants meet three times, each session lasting for 1 ½-2 hours. If meeting in mixed-gender groups, the activities in both of the first two sessions consist of party games (e.g., Win, Lose, or Draw). If a group is composed entirely of same-gender participants, during the second session, the group views slides of opposite-gender individuals taken from magazines and advertisements and debates the attractiveness of these individuals. The third session consists of a presentation by a group leader and a wrap-up discussion of alcohol expectancies.

The intervention can be conducted such that in the first two sessions, either half of those who are of legal drinking age receive alcohol and the rest the placebo, or everyone receives the placebo. If all receive the placebo, the actual results of the identification task are not discussed until the second session.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Studies have shown that this procedure can significantly reduce positive alcohol expectancies in both men and women, although the changes are greater for men and do not appear to last as long for women (Darkes & Goldman, 1993; 1998; Dunn, Lau, & Cruz, 2000; Musher-Eizenman & Kulick, 2003). Although all participants reported experiencing very little pressure to change their drinking habits, men who were relatively heavy drinkers before participating reduced their consumption of alcohol by about 40% by six weeks after participation. There is no evidence that women's drinking patterns are affected by intervention participation.

RESOURCES REQUIRED

The activity requires collins mix, lemons, glasses, vodka, and flat tonic. Specific instructions and training on how to conduct the intervention are available from the intervention's developer (see below).

WHERE TO FIND MORE INFORMATION

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Email: darkes@chuma1.cas.usf.edu

Team Awareness (see page 28)

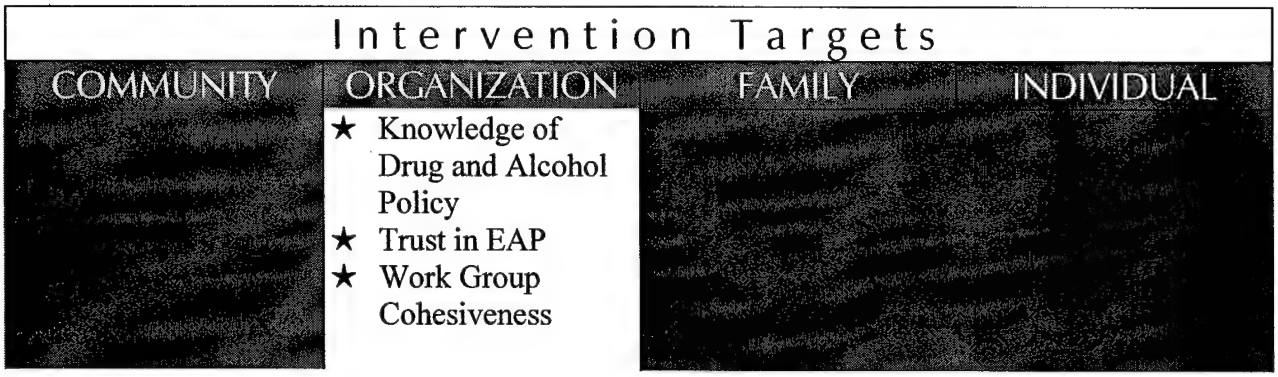

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Chart 1.

Empirical Evidence Rating Chart

Activity/ Interventions

Rating		Page # (s)
Best	Team Awareness	28, 102
	Prevention and Relationship Enhancement Program (PREP)	32
	Triple P (Ages birth-12)	38, 44, 49, 84, 96
	Cognitive Appraisal Program (Ages birth-1)	47, 96
	Incredible Years BASIC (Ages 3-8)	54
	Parents Who Care - Guiding Good Choices (ages 9-14)	56
	5 A Day	68
	Cognitive Relaxation Coping Skills (CRCS)	88
	Feeling Good	94
Better	Community Gardens	13, 70, 85
	Personal Stereo Use	21
	Relationship Enhancement (RE)	34
	Couples Coping Enhancement Training (CCET)	36, 44, 85
	Incredible Years ADVANCE (Ages 3-8)	42
	Common Sense Parenting® (Ages 2-17)	52
	Parenting Wisely (Ages 8-18)	58
	Point-of-Decision Prompts	65
	Self-Control Training	76
	Changing the Sexual Aggression-Supportive Attitudes of Men	89
	Alcohol Expectancy Challenge	100
Good	Neighborhood Watch/Working it Out	15
	Improved Street Lighting	17
	Stress. . .at Work	23
	RETHINK	60, 91
	NoonTime Walkers	66, 84
	EDSA Group® Workshops	74
	Stress and the Healthy Mind	76, 80, 97
	Unstress	82

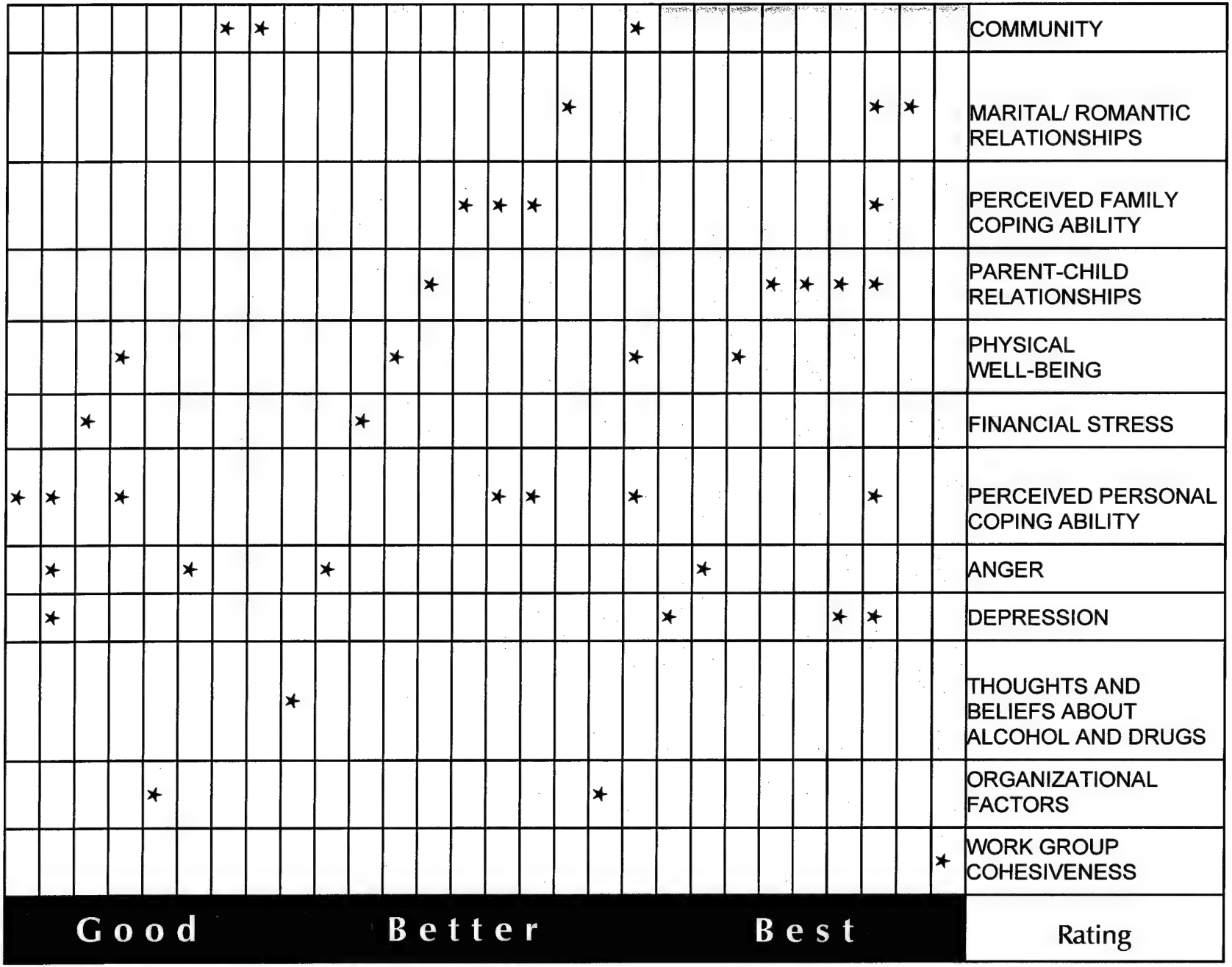
COMMUNITY
MARITAL/ ROMANTIC RELATIONSHIPS
PERCEIVED FAMILY COPING ABILITY
PARENT-CHILD RELATIONSHIPS
PHYSICAL WELL-BEING
FINANCIAL STRESS
PERCEIVED PERSONAL COPING ABILITY
ANGER
DEPRESSION
THOUGHTS AND BELIEFS ABOUT ALCOHOL AND DRUGS
ORGANIZATIONAL FACTORS
WORK GROUP COHESIVENESS
Good
Better
Best
Rating

Chart 2.

Risk Factor(s) Addressed

Activity/ Interventions

	Page #	Community				Organizational Factors			
		Community Safety	Community Satisfaction	Community Unity	Support from Neighbors	Work Group Cohesiveness	Satisfaction with Employing Organization	Trust in EAP	Job Stress
COMMUNITY									
Community Gardens	13			★	★				
Neighborhood Watch/Working it Out	15	★	★	★					
Improved Street Lighting	17	★							
ORGANIZATIONAL FACTORS									
Personal Stereo Use	21						★		★
Stress. . .at Work	23								★
WORK GROUP COHESIVENESS									
Team Awareness	28					★		★	
MARITAL/ROMANTIC RELATIONSHIPS									
Prevention and Relationship Enhancement Program (PREP)	32								
Relationship Enhancement (RE)	34								
Couples Coping Enhancement Training (CCET)	36								
Triple P	38								
PERCEIVED FAMILY COPING ABILITY									
Incredible Years ADVANCE (Ages 3-8)	42								
Triple P	44								
Couples Coping Enhancement Training (CCET)	44								
PARENT-CHILD RELATIONSHIPS									
Cognitive Appraisal Program (Ages birth-1)	47								
Triple P (Ages birth-12)	49								
Common Sense Parenting® (Ages 2-17)	52								
Incredible Years BASIC (Ages 3-8)	54								
Parents Who Care - Guiding Good Choices (ages 9-14)	56								
Parenting Wisely (Ages 8-18)	58								
RETHINK	60								

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page #	Community				Organizational Factors			
		Community Safety	Community Satisfaction	Community Unity	Support from Neighbors	Work Group Cohesiveness	Satisfaction with Employing Organization	Trust in EAP	Job Stress
PHYSICAL WELL-BEING									
Point-of-Decision Prompts	65								
NoonTime Walkers	66								
5 A Day	68								
Community Gardens	70			★	★				
FINANCIAL STRESS									
EDSA Group® Workshops	74								
Self-Control Training	76								
PERCEIVED PERSONAL COPING ABILITY									
Stress and the Healthy Mind	80								
Unstress	82								
NoonTime Walkers	84								
Triple P	84								
Couples Coping Enhancement Training (CCET)	85								
Community Gardens	**85**			★	★				
ANGER									
Cognitive Relaxation Coping Skills (CRCS)	88								
Changing the Sexual Aggression-Supportive Attitudes of Men	89								
Stress and the Healthy Mind	91								
RETHINK	91								
DEPRESSION									
Feeling Good	94								
Cognitive Appraisal Program	96								
Triple P	96								
Stress and the Healthy Mind	97								
THOUGHTS AND BELIEFS ABOUT ALCOHOL AND DRUGS									
Alcohol Expectancy Challenge	100								
Team Awareness	**102**					★		★	

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page #	Family										
		Marital/Romantic Relationships	Parents' Sense of Competence	Parent-Child Relationships	Perceived Family Coping	Child Externalizing Behavior	Child Internalizing Behavior	Inappropriate Expectations for Children's Behavior	Special Needs of Child(ren)	Total Child Abuse Potential	Total Child Behavior Problems	Use of Corporal Punishment
COMMUNITY												
Community Gardens	13											
Neighborhood Watch/Working it Out	15											
Improved Street Lighting	17											
ORGANIZATIONAL FACTORS												
Personal Stereo Use	21											
Stress. . .at Work	23											
WORK GROUP COHESIVENESS												
Team Awareness (see page ****)	28											
MARITAL/ROMANTIC RELATIONSHIPS												
Premarital Relationship Enhancement Program (PREP)	32	★										
Relationship Enhancement (RE)	34	★										
Couples Coping Enhancement Training (CCET)	36	★			★							
Triple P	38	★	★	★	★	★	★					
PERCEIVED FAMILY COPING ABILITY												
Incredible Years ADVANCE (Ages 3-8)	42				★							
Triple P	44	★	★	★	★	★	★					
Couples Coping Enhancement Training (CCET)	44	★			★							
PARENT-CHILD RELATIONSHIPS												
Cognitive Appraisal Program (Ages birth-1)	47			★					★			
Triple P (Ages birth-12)	49	★	★	★	★	★	★					
Common Sense Parenting® (Ages 2-17)	52		★	★		★				★	★	
Incredible Years BASIC (Ages 3-8)	54			★		★					★	★
Parents Who Care - Guiding Good Choices (ages 9-14)	56			★		★						
Parenting Wisely (Ages 8-18)	58			★		★						
RETHINK	60		★					★				★

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page #	Family										
		Marital/Romantic Relationships	Parents' Sense of Competence	Parent-Child Relationships	Perceived Family Coping	Child Externalizing Behavior	Child Internalizing Behavior	Inappropriate Expectations for Children's Behavior	Special Needs of Child(ren)	Total Child Abuse Potential	Total Child Behavior Problems	Use of Corporal Punishment
PHYSICAL WELL-BEING												
Point-of-Decision Prompts	65											
NoonTime Walkers	66											
5 A Day	68											
Community Gardens	70											
FINANCIAL STRESS												
EDSA Group® Workshops	74											
Self-Control Training	76											
PERCEIVED PERSONAL COPING ABILITY												
Stress and the Healthy Mind	80											
Unstress	82											
NoonTime Walkers	84											
Triple P	**84**	★	★	★	★	★	★					
Couples Coping Enhancement Training	**85**	★			★							
Community Gardens	**85**											
ANGER												
Cognitive Relaxation Coping Skills (CRCS)	88											
Changing the Sexual Aggression-Supportive Attitudes of Men	89											
Stress and the Health Mind	89											
RETHINK	**91**		★					★				★
DEPRESSION												
Feeling Good	94											
Cognitive Appraisal Program	**96**	★			★							
Triple P	**96**	★	★	★	★	★	★					
Stress and the Healthy Mind	97											
THOUGHTS AND BELIEFS ABOUT ALCOHOL AND DRUGS												
Alcohol Expectancy Challenge	100											
Team Awareness	102											

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page #	Individual											
		Anger/ Hostility	Anxiety	Depression	Financial Stress	Perceived Personal Coping	Self Esteem	Approval of Aggression	Alcohol Expectancies	Knowledge of Drug and Alcohol Policy	Physical Activity	Healthy Diet
COMMUNITY												
Community Gardens	13					★						★
Neighborhood Watch/Working it Out	15											
Improved Street Lighting	17											
ORGANIZATIONAL FACTORS												
Personal Stereo Use	21											
Stress. . .at Work	23											
WORK GROUP COHESIVENESS												
Team Awareness	28									★		
MARITAL/ROMANTIC RELATIONSHIPS												
Premarital Relationship Enhancement Program (PREP)	32											
Relationship Enhancement (RE)	34											
Couples Coping Enhancement Training (CCET)	36					★						
Triple P	38		★	★		★						
PERCEIVED FAMILY COPING ABILITY												
Incredible Years ADVANCE (Ages 3-8)	42											
Couples Coping Enhancement Training	44					★						
Triple P	44		★	★		★						
PARENT-CHILD RELATIONSHIPS												
Cognitive Appraisal Program (Ages birth-1)	47			★								
Triple P (Ages birth-12)	49		★	★		★						
Common Sense Parenting® (Ages 2-17)	52											
Incredible Years BASIC (Ages 3-8)	54											
Parents Who Care - Guiding Good Choices (ages 9-14)	56											
Parenting Wisely (Ages 8-18)	58											
RETHINK	60	★										
PHYSICAL WELL-BEING												
Point-of-Decision Prompts	65										★	
NoonTime Walkers	66		★			★					★	
5 A Day	68											★
Community Gardens	70					★						★

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page #	Individual										
		Anger/Hostility	Anxiety	Depression	Financial Stress	Perceived Personal Coping	Self-Esteem	Approval of Aggression	Alcohol Expectancies	Knowledge of Drug and Alcohol Policy	Physical Activity	Healthy Diet
FINANCIAL STRESS												
EDSA Group® Workshops	74				★							
Self-Control Training	76				★							
PERCEIVED PERSONAL COPING ABILITY												
Stress and the Healthy Mind	80	★	★	★		★	★					
Unstress	82		★			★						
NoonTime Walkers	84		★			★					★	
Triple P	84		★	★		★						
Couples Coping Enhancement Training	85					★						
Community Gardens	85					★						★
ANGER												
Cognitive Relaxation Coping Skills (CRCS)	88	★										
Changing the Sexual Aggression-Supportive Attitudes of Men	89							★				
Stress and the Healthy Mind	91	★	★	★		★	★					
RETHINK	91	★										
DEPRESSION												
Feeling Good	94			★								
Cognitive Appraisal Program	96					★						
Triple P	96		★	★		★						
Stress and the Healthy Mind	97	★	★	★		★	★					
THOUGHTS AND BELIEFS ABOUT ALCOHOL AND DRUGS												
Alcohol Expectancy Challenge	100								★			
Team Awareness	102									★		

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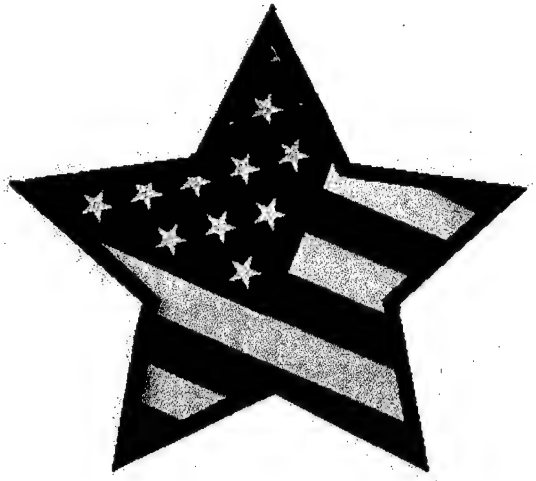

NORTH STAR Training Manual

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STONY BROOK
STATE UNIVERSITY OF NEW YORK

In Collaboration with
AF Community Prevention Division (AFMSA/SGOF)
Brooks City Base, TX

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NORTH STAR Introduction

The goal of NORTH STAR is to prevent and reduce serious problems of family maltreatment, substance abuse, and suicidality for which adults are reluctant to seek help. NORTH STAR addresses them by focusing on the risk factors typically associated with such secretive problems, and it uses a scientifically proven program to accomplish this.

Purpose of Manual

This manual is designed to guide you through all phases of your community assessment (CA) from interpreting your data to creating a data-driven plan. Although the manual cannot replace NORTH STAR training, it can serve as an introduction for anyone new to NORTH STAR or anyone not able to attend the training sessions. It also serves as a continuous reference guide following training.

Contents

The manual has these major components:

- Section 1: Orientation to NORTH STAR
- Section 2: Base Data (guidelines for reading and interpreting)
- Section 3: Worksheets (for prioritizing objectives)
- Section 4: Guidebook (directions on using it to design a community action plan)
- Section 5: Evaluation

The Guidebook is continuously updated to reflect the most current material available. Updated material and additional supplements can also be found at the NORTH STAR web site, www.northstarguide.org.

Section 1 — Orientation to the Project

I. What is NORTH STAR?

The goal of NORTH STAR is to enhance AF readiness by proactively reducing death and injury that result from family maltreatment, suicidality, and alcohol and drug problems. The project enhances IDS efforts by using community data to identify critical needs and applying scientifically proven programming to address them. NORTH STAR is the result of a long standing partnership between the AF's c and investigators at State University of New York at Stony Brook and is the result of collaborative research on family maltreatment within the AF. It represents a state-of-the-art approach that combines existing prevention infrastructure on bases (the IDS) with data-based research being conducted by the Community Prevention Division.

NORTH STAR focuses on family maltreatment, suicidality, and substance abuse for a number of reasons. First, repercussions of such problems can extend far beyond just the individual or family involved. Severe incidents can trigger effects throughout a base and greater community for months. Second, these problems are regularly identified by commanders as being among their top concerns. Third, such problems are often kept secret until they become too serious to correct. Fourth, and perhaps most importantly, these problems are caused by overlapping risk and protective factors and these factors, the Community Results in the Community Capacity model, are the very ones the IDS was created to address.

Thus, NORTH STAR is intended as the next phase in the evolution of the IDS. It formalizes evidence-based prevention practices to help base IDS teams use data to identify the keys to strengthening their communities. IDS teams are not asked to solve complex problems with guesswork. Rather, decisions and activities are driven by hard data.

Although NORTH STAR is new, communities using similar approaches have had success in improving youth problems, for example improved cognitive skills, 30% reduction in school problems, and nearly 30% decrease in drug and assault charges.

NORTH STAR's first bases collaborate with the Stony Brook research team and receive ongoing consultation on how to maximize use of their data. This not only enhances local capacity, but also positions them to serve as models for other communities.

NORTH STAR focuses on prevention rather than treatment. To concentrate prevention efforts most effectively, it targets not only the factors that cause problems, but also the problems that are relevant to the overall health of the entire community — factors like stress and community cohesion. Targeting factors such as these potentially improves the functioning of the entire community as well as prevents more severe problems.

The full details of the NORTH STAR process are outlined in this manual. Base IDS teams identify priorities based on the results of their CA. They then use the Guidebook, a compilation of proven intervention strategies for every CA risk and protective factor, to select programs and activities and implement them. Finally, they evaluate their efficacy, and the cycle of improvement begins again.

II. Collaboration between Stony Brook and the Air Force

A. Project History

In 1997, AF Family Advocacy personnel recognized a great challenge that lay before them. They wished to shift to a proactive model of outreach and prevention of family maltreatment problems. However, it was impossible to collect data on the impact of these efforts because no one knew how much maltreatment was actually going undetected in the community.

It was hard to predict what effect any outreach might have. Would it cause more people to seek help? Would it cause an increase in family maltreatment episodes? Neither could be determined without first knowing the true population prevalence of the problem. In addition, resources were limited and any method used to track problems would have to be cost-effective.

So, the Algorithm Project was commissioned. Researchers at Stony Brook determined that it *was* possible to develop estimation models (i.e., algorithms) based on information that was already assessed in the CA and update the estimates of the population prevalence of maltreatment on individual AF bases. Answers to questions such as those on the CA were found to estimate prevalences within one percentage point of an actual measured prevalence.

In order to develop estimation models, the CA and an additional problems assessment needed to be administered at least once. Combined use of the CA and this supplemental survey provided a very powerful information base, not only for estimating prevalence, but also for strategically enhancing the functioning of base communities.

As the Algorithm Project progressed, three other developments occurred. First, the AF instituted the CAIB and IDS at all bases. Second, the CA underwent a substantial revision that transformed it from a relatively loose collection of questions about community, agency, and individual factors to a tightly constructed assessment tool based on the Community Capacity Model. Now, the CA could strongly assess a gamut of indicators of overall level of functioning and important risk and protective factors for a wide range of outcomes. Third, tremendous advances were made in community-based prevention efforts, especially those directed at a range of youth problems. These advances suggested that by pairing high-quality data with a strong community-oriented prevention infrastructure and interventions, communities could reduce problems and improve the quality of life for families.

These three developments, along with the information system that would be developed as part of the Algorithm Project, formed the basis of NORTH STAR.

B. Stony Brook Support of the IDS

The first bases to implement NORTH STAR enjoy enhanced functioning of their own IDS and community, and also participate in an evaluation of NORTH STAR to benefit other AF communities. Therefore, early users of the model receive additional support and resources from the research team. Through collaboration, the partners determine how to best implement strategies and share them with other IDS teams to build the AF's capacity for independence. Below are some the activities that characterize this collaboration.

IDS will:

- identify and prioritize community needs based on Community Assessment data.
- choose activities based on the Guidebook of proven strategies.
- draft and implement a year-long action plan to target the risk and protective factors selected.
- develop a plan to maintain faithful implementation of selected programs.
- develop a plan to monitor short-term program impact.
- conduct regular CAIB briefings on the status of these efforts.
- communicate findings from evaluations and briefings to Stony Brook staff.

Stony Brook will:

- provide consultation and assistance to the IDS.
- assess IDS members and leadership periodically on their satisfaction with NORTH STAR, their confidence in their abilities to make community changes, and their enactment of the community action plan.
- assess the penetration and breadth of programs being implemented once they are firmly established.
- review the next CA with the base to evaluate the impact of past efforts.

Throughout the year, Stony Brook's contact with the Air Force primarily takes the form of regular email and phone consultation so that researchers can gather information and problem solve. They also provide templates of briefing material to bases and facilitate communication among the bases via a listserv and scheduled conference calls.

In addition, researchers provide an annual visit at the convenience of base personnel. On-site consultation focuses on supporting IDS efforts in any phase of the project where it is most needed, from planning to implementation to evaluation.

Personnel at the first bases to adopt the IDS enhancements have an important voice in how this effort progresses. Stony Brook works closely with IDS teams to determine what resources to add. As a result, NORTH STAR is shaped to better serve not only your own IDS but also those elsewhere.

C. NORTH STAR Resources Available from Stony Brook

- Training Guide
- Worksheets
- Guidebook
- Website
- Listserv
- Stony Brook Team
- Consultation visits

III. Definitions and Rationale

A. What is science-based prevention?

Science-based prevention is founded on the premise that we maximize progress by building on what is already known. Experienced professionals avoid the inefficiency of "reinventing the wheel" by sharing successful methods and techniques with colleagues. In doing so, they help others avoid the pitfalls from which they have already learned. When a problem arises, the less experienced can benefit from the guidance of the more experienced.

NORTH STAR is a science-based approach to prevention on a number of levels. All decisions are data driven and based on CA results. All the strategies included in the NORTH STAR Guidebook of activities have been evaluated and have a proven track record of effectiveness. Further, implementations are evaluated and adjusted based on actual results. Stony Brook researchers and IDS teams work together to determine the impact of community efforts and to continuously refine plans.

B. What are risk and protective factors?

Risk factors are contributing antecedents to problem behaviors. For example, having an under active thyroid or keeping two gallons of ice cream in your freezer at all times might be two risk factors for overeating. In contrast, protective factors mitigate risk for problem behaviors. Examples of protective behaviors might be having a high metabolism and avoiding fast food restaurants.

Risk and protective factors can characterize individuals, families, organizations, and communities. Individual risk factors include depression or poor money management skills. Family risk factors include poor parenting skills or being in an unhappy marriage. Organizational factors include work demands and employee cohesion. Community factors include safety and community efficacy.

Some risk and protective factors are fixed, such as nationality or family medical history. Other factors are changeable and vary in how easily or quickly they might be changed. For example, it might be easier to change one's exercise habits than marital status.

Risk and protective factors also vary in the strength of their relationships with problem behaviors. For example, a person's use of cigarettes might be more strongly related to their risk of heart disease than their grandparents' causes of death. This is known as the effect size of a factor.

Because the goal of NORTH STAR is to improve community well-being and reduce the prevalence of problems, the focus is on changeable risk and protective factors, and you will be asked to consider effect size when you are selecting target factors.

C. Why use science-based prevention?

NORTH STAR's method is targeted at the whole community. It uses scientifically-proven programming to target risk and protective factors for various problems — those most related to a community's well-being — rather than only on difficult problems themselves. This allows at-risk individuals and groups to be identified and supported before serious problems actually erupt.

Because problematic levels of risk and protective factors characterize a larger proportion of any population than do actual target problems, it is helpful to use them to alter a community profile. Risk and protective factors are not as stigmatizing as full-blown problems, so people tend to be less resistant to participating in activities designed to correct them. This is especially true in military communities where target problems can sometimes have serious career implications and are, therefore, often concealed.

Dealing with changeable risk factors can have a positive ripple effect throughout a community. Altering risk levels can reduce or prevent target problems themselves, but it can also improve risk profiles of related problems. So, targeting risk and protective factors with empirically-supported programming is an efficient and high impact method for reducing target problems.

NORTH STAR sites receive data on these factors to guide action planning. The Guidebook serves as an additional resource of scientifically proven activities that target each of these factors.

D. What are empirically-supported programs?

Empirically-supported programs, sometimes called evidence-based practices, are those which have been clearly found to be substantiated by scientific evidence. Most of the risk and protective factors in the CA have been extensively researched by numerous experts from a variety of disciplines.

While their findings are, technically, available to everyone, it is unrealistic to expect that a busy professional could conduct a thorough literature search every time the need arose to develop or refine a program. For this reason, the NORTH STAR Guidebook provides summaries of empirically-supported programs that have been rigorously tested and demonstrate power to change a community's risk and protective factors.

To be included in the Guidebook, a program must have been evaluated for its impact on the factor and had its evaluation results made public for review. Programs are excluded if they:

- did not include a measure of the factor in their evaluation.
- were evaluated only for participant satisfaction, not impact on the risk factor.
- were never been evaluated.

Programs included in the Guidebook may vary in the strength of their supporting evidence, but all are proven to have an effect. The strongest form of evidence results from randomized, controlled trials. This type of study best indicates that any resulting change was attributable to the program and not some other confounding factor present in the community at the time the program was run. Studies without randomly assigned control groups can provide evidence of impact, but they generally need to be larger and more carefully designed to support conclusions regarding efficacy.

IV. The NORTH STAR Process

A. Focus on the Factors

The first step in developing a science-based action plan is to select high priority risk and protective factors based on data. These factors become the target of IDS efforts until the next community assessment. It is important to select only one or two factors because (a) a focused approach is more likely to change community-level risk factors in a meaningful way, (b) if one factor is successfully targeted and changed, others may also be affected, and (c) the transformation in overall community well-being is greater as the result of much change on one factor than small changes on several factors.

When selecting factors, it is critical to consider the results of the most recent CA, the base priorities, and the availability of empirically-supported, appropriate interventions. CA results are organized to highlight factors that are most likely to be problems at your base.

B. Community Assessment (CA)

The CA of 2003 is the culmination of several years of planning and, as a result, is no longer a loose collection of individual items of specific relevance. Rather, it was built to reflect the Community Capacity model and the collaborative nature of the IDS. The CA is NORTH STAR's primary source of data and has generally been administered biennially.

This new CA assesses factors by including demographic variables and groupings of items in the Community Capacity model. The items were drawn from the scientific literature to ensure the most reliable and valid assessment of these factors. Representative AD members and civilian spouses at each base were invited to participate. (Reservists were also sampled, but their data did not form the basis of IDS action planning in NORTH STAR.)

C. The Community Capacity Model

The AF's Community Capacity model focuses on the entire community rather than on a specific agency or demographic group within. The underlying logic is that strong inter-agency collaboration results in deeper connections among community members, producing a more resilient, higher-functioning community. The community, in turn, is able to support a greater quality of life among its members.

D. The CA as a Measure of Risk and Protective Factors

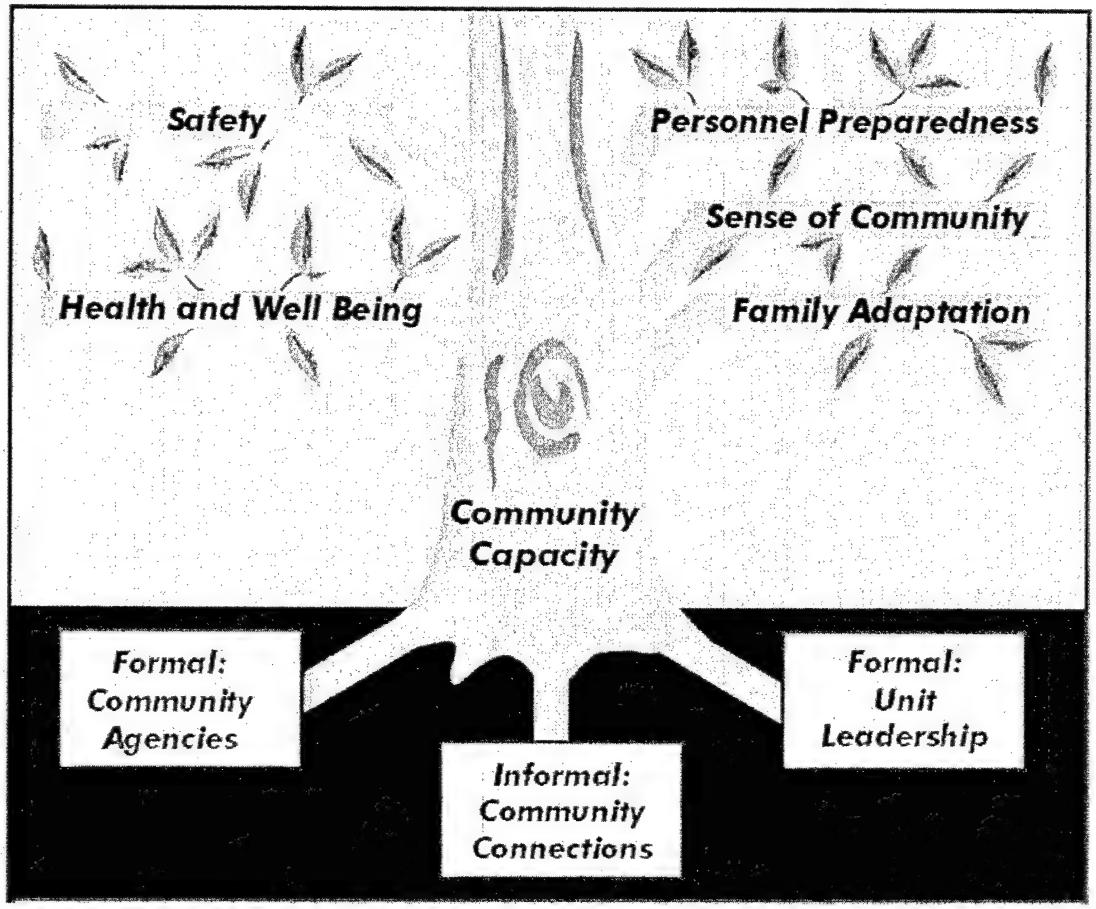
Because of the CA's new content, all items and scales were tested for reliability and validity. Since some of the variables in the Community Capacity model were so closely related, they were able to be combined. This resulted in a stronger assessment of certain variables, and eventually, in streamlined work for IDS.

Following analysis, the CA's non-demographic items clustered into 24 separate scales, each assessing a different variable in the Community Capacity model. These variables fall into four categories: Community, Organizational, Family, and Individual/Personal.

Each category groups closely related risk and protective factors. The base-specific Feedback Report includes analyses on how significant a risk or protective factor each CA

variable is for each target problem. This helps clarify the leverage points to improving a particular base.

A few important and potentially changeable factors were *not* assessed in the CA, such as poor anger control. There might be an instance when the IDS would prefer to target one of these risk or protective factors. However, before such a factor can be used for evidence-based decision making, it must first undergo at least a cursory check of efficacy.



E. Using the CA Findings to Prioritize Factors

Whenever the IDS embarks on a decision making process, it draws from information related to the CA, the base priorities, and agency capacity. The task of selecting risk and protective factors is no different. An introduction to this method is outlined below and specified in detail later in Section 3 (Worksheets).

1. Examine the prevalences of target problems and compare them to benchmarks.

Benchmarks in the Feedback Reports are based on the most up-to-date studies available. Cases where the benchmarks are not entirely generalizable are noted in the table. There may be instances where a benchmark is of interest but not a strong influence in prioritizing factors. (For example, the benchmark for suicidality may be substantially lower than what is found at your base. However, you may decide that no rate of suicide is acceptable and choose to target the associated risk factors anyway.)

2. **Review the strength of relationships between the CA variables and the target problems.**

Benchmarks reveal the factors' relationships with the targeted problems. The strength of each relation is indexed with a correlation coefficient. Correlation coefficients range from -1 to +1. A correlation of either +1 or -1 indicates a perfect relationship. A correlation of 0 indicates no relation. Positive correlations mean that as one variable goes up, the other goes up. Negative correlations mean that as one variable goes up, the other goes down.

Once targeted, risk and protective factors are ranked according to the strength of these relationships.

3. **Examine the specificity/generality of the relation.**

A risk or protective factor that is moderately related to several target problems might be considered more critical to change than a factor related to only one.

4. **Review the information in relation to community programming already in place.**

Since NORTH STAR activities are intended to supplement rather than supplant existing ones, consideration is given to whether established remedies are working or need to be replaced.

F. The Guidebook

Specific directions for use of the Guidebook and planning sheets appear in Section 4 of this manual.

Once the steps above are carried out, the IDS team is in a position to determine which of NORTH STAR's empirically-supported interventions appear promising. Priority is placed on interventions that are appealing over those with little proven technology for changing them or that may appear cumbersome.

The Guidebook is divided into Community, Family, and Individual sections. Each section contains chapters organized by risk and protective factors. Because of the nature of some factors, a few lack intervention summaries. (Either no interventions have been evaluated or none of the evaluated interventions demonstrated any effect.)

Most factors have a choice of accompanying interventions which are rated "good", "better", and "best" according to the strength of their supporting evidence base. Intervention activities require at least a rating of "good" to be included in the Guidebook.

Additional information, such as estimated costs or contact information, steers IDS teams toward wise program decisions and helps customize solutions for a particular base. When selecting activities, especially consider:

- feasibility.
- fit with the base and existing programming at the base.
- strength of the evidence supporting the effectiveness of the activity.

The Guidebook is updated by Stony Brook researchers who continue to survey the latest literature. Their findings result in ongoing revisions to the information that are updated on the NORTH STAR website (www.northstarguide.org), the listserv, and print materials.

Section 2 — Base Data

I. Feedback Report

The Feedback Report is a summary of base data. It includes descriptions of problem behaviors found on base, an overview of NORTH STAR, benchmarks by which to judge the severity of problems, and an assessment of the relationship between specific risk and protective factors and problem behaviors.

II. Sources for the Measures

A. Community Assessment

The CA tool was built on the concepts that are at the heart of the Community Capacity Model. The questions are the end result of close examination of important community issues. The Feedback Report lists the constructs used in the survey. When a construct in the CA is found to be related to a target problem, the construct may be regarded as a risk or protective factor.

Questions in the CA are grouped to create scales that measure specific concepts. For example, questions on marital satisfaction are:

What is your level of agreement with each of the following statements about your relationship with your spouse?

	STRONGLY AGREE	AGREE	SLIGHTLY AGREE	SLIGHTLY DISAGREE	DISAGREE	STRONGLY DISAGREE
a. We have a good relationship.	0	0	0	0	0	0
b. My relationship with my spouse is very stable.	0	0	0	0	0	0
c. I feel like part of a team with my spouse.	0	0	0	0	0	0
d. I am committed to making my marriage a success.	0	0	0	0	0	0

B. Target Problem Assessment

The AF prevention program primarily targets three issues: family maltreatment, alcohol abuse and drug use, and suicidality. These risky behaviors are frequently concealed because of perceived AF career implications for PRP status, flight status, security clearances, and social stigma. Due to secrecy, the issues are not always brought to the attention of community helping agencies. By assessing the target problems anonymously, the target problem assessment may shed light on their true prevalence.

Data gathered in the supplement place problems along a continuum ranging from mild to serious enough to warrant intervention. Sometimes, it is difficult to pinpoint the severity of a problem along the continuum. (For example, drinking two beers per week is not considered problem behavior. However, drinking two or three martinis a day can affect one's day-to-day functioning.) The supplement incorporates expert input on such variables and identifies at which points they are considered low or high risk.

To measure risk of suicidality, the supplement measures levels of depression. To measure risk of family maltreatment (such as physical abuse, emotional abuse, or neglect abuse of a spouse of children), the supplement includes questions about family behaviors.

Supplement measures were developed over several years of testing and feedback from AD members and spouses. The instrument balances brevity (use of skip patterns) with the need for enough detailed information to gauge if behavior crossed threshold levels.

The supplement measures:

- alcohol use via the Alcohol Use Disorders Identification Test (AUDIT)
- prescription drug misuse (used without prescription or exceeded dosage)
- illicit drug use
- suicidality (suicidal thinking and behavior)
- partner physical abuse (perpetration and victimization)
- partner emotional abuse victimization
- child physical abuse perpetration
- child emotional abuse perpetration
- child neglect perpetration (lack of supervision, exposure to physical hazards)

III. How to read your feedback report

The report begins with a summary of the overall prevalences of secretive problems on the base. It also shows how many respondents reported more than one secretive problem.

The next sections provide detailed information about each target problem. For each problem, a bar chart illustrates its prevalence.

The sections on each problem also show the strength of the risk and protective factors. Below is an example for spouse physical abuse. Correlations are listed with the strongest association first

Sample Table. *Spouse physical abuse: CA risk and protective factors (above r = .2)*

Risk/Protective Factor	*r*
Relationship satisfaction	.270(**)
Perceived family coping	.289(**)
Perceived coping ability of spouse/significant other	.287(**)

** Correlation is significant at the 0.01 level (2-tailed).

For example, in the table above, relationship satisfaction has a higher correlation with spouse physical abuse than does perceived coping ability of spouse/ significant other. Therefore we can conclude that the stronger relationship exists between Spouse physical abuse and Relationship Satisfaction.

Demographics tables appear later in the report. To compare a population struggling with a particular issue with the general base populations, read horizontal rows of data. To compare target audiences for various programs, compare figures vertically.

The prevalences of each measure are summarized at the end of the report.

Section 3 — Worksheets

The process of selecting factors to consider for interventions is not linear. As your overall progress may move forward, it may be necessary to intermittently back up and reassess some decisions. The accompanying worksheets are designed to help.

Worksheets 1 and 2 aid in examining data from a variety of angles in order to familiarize the IDS teams with problem prevalences and their associated risk and protective factors. Later planning sheets help bring in other considerations that are base-specific and which may not be represented in the Feedback Report summaries. Making use of the Worksheets will ensure that all possibilities for planning have been considered.

I. Worksheet 1: Prevalence and Factors Table

The first step in choosing appropriate programming is to organize results from the Feedback Report in such a way that a great deal of information may be viewed simultaneously. Worksheet 1 allows space to indicate both the prevalence of risk and protective factors at your particular base, and the strength of the relationships between the factors and their associated problems.

A. Prevalence of target problems

The Feedback Report organizes problems in decreasing order of prevalence. Keep the benchmarks numbers in perspective. While they provide the best available information, they are not always from studies that used the same methods and measures as the CA, and so might not be perfectly comparable.

Also remember that a high prevalence problem may not be the problem that is prioritized by IDS. Problem prevalence is only part of the equation and there is a range of explanations. Some problems have a higher impact on readiness than others, or perhaps changing one target problem would lower the chance of success with another.

Another consideration is whether other solutions are already underway to address a problem. If measures are being effectively implemented, or if they are too new to assess, it would be wise to continue them and give their associated problems lower priority

Finally, use target populations to guide choices. Problems that affect a larger number of community members should be prioritized over those impacting fewer people. For example, if a problem only affects families with six or more children, it might be more prudent to dedicate resources to solving a different problem.

B. Strength of association

Next, assess the strength of associations between risk and protective factors and their target problems. The strengths vary from very strong to only marginal and the higher the *r* value, the closer the relationship.

A positive number indicates a positive relationship; as one variable goes up, the other goes up. A negative number indicates an inverse relationship; as one variable goes up, the other goes down.

See the sample of Worksheet 1 (next page). In the case of spouse physical abuse, community stressors have a positive relationship, whereas support of significant other has a negative relationship.

Some risk factors may be linked with more than one problem and thus make very attractive risk factors to prioritize. Hitting more than one target problem with one activity can be a strong incentive to choose one risk factor over another. For example, perceived family coping is a risk factor that shows up as correlated to suicidality, child emotional abuse, child physical abuse, spouse physical abuse and spouse emotional abuse. The possibility of having an impact on five targets makes perceived family coping a much more attractive target than spiritual well being which only shows a connection with one target problem.

C. Directions

1. First Column: Prevalences and Benchmarks

In the first column under the problem headings, fill in the prevalence and benchmark numbers found in the bar chart sections of the Feedback Report.

2. Next columns: Strength of Association

Use the tables to locate risk and protective factors. Use the list on pages 3-4 to place factors into their correct columns: Community, Organizational, Family, and Individual. Remember to include the *r* number that indicates strength of relationship.

Worksheet 1 — *sample*

Directions: Use the Feedback Report to retrieve information and values.

1. *First column*: Use the bar charts to indicate prevalence and benchmark values.
2. *Other columns*: Use the tables to indicate risk and protective factors. See the list on pages 3-4 to place factors into their correct columns: Community, Organizational, Family, or Individual. Remember to include the *r* number that indicates strengths of relationships.

Target Problem Prevalence/ Benchmark		**Risk and Protective Factors/ Strength of Association**							
		Community		**Organization**		**Family**		**Individual**	
Spouse Physical Abuse		♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂
Prevalence	Benchmark	Community stressors .13				Support of sig. other -.17	Perc. family coping -.12	Financial Stress .16	Financial Stress .11
♂→♀ 1.80%	2.10%					Marital satis. -.13	Support of sig. other -.11		Personal coping -.11
♀→♂ 1.90%	2.10%					Family coping -.14	marital satis. -.11		
Spouse Emotional Abuse		♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂
Prevalence	Benchmark	Community stressors .13			Job Stress -..05	Marital satisfaction -.14	Physical well being -.09	Depressive Symptom. .24	Perc. personal coping -.09
♂→♀ 10.1%	No Benchmark				Work group cohesion -.06	Support of sig. other -.13	Perc. family coping -.05	Perc. Personal coping -.20	Depressive Symptom. .08
♀→♂ 7.9%						Perc. family coping -.12	X	Phys. well being -.15	Physical well being -.09
						coping ability of spouse -.12			
Child Physical Abuse		Supp. from neighbors -.05		Work group cohesion .06		Marital satisfaction -.07		personal coping -.06	
Prevalence	Com. stressors -.04					Perc. family coping -.06		Depressive Sympt. .05	
	Com. Support/ youth					Parenting satisfaction -.05		Financial Stress .04	
7.10%	-.04					Spouse coping -.07			
Child Emotional Abuse		Social support -.08				Perc. family coping -.11		personal coping -.12	
Prevalence	Benchmark	Instrumental support -.08				Parenting satisfaction -.09		Depressive Sympt. .09	
5.00%	No Benchmark								

Target Problem Prevalence/ Benchmark		Risk Factors/ Strength of Association			
		Community	**Organization**	**Family**	**Individual**
Child Neglect			Job Stressors .07	Family coping -.06	Physical well being -.06
Prevalence	Benchmark			spouse coping ability -.06	personal coping -.05
35.35%	No Benchmark			Parenting satisfaction -.05	
Alcohol		Community safety -.08			Depressive Symp. .11
Prevalence	Benchmark	Support of neighbors -.11			Personal military preparedness -.12
7.75%	6.40%	Community unity -.08			Spiritual well being -.10
		Community stressors .09			Depressive Symp. .11
Street Drug Use					
Prevalence	Benchmark				
.60%	1.80%				
Prescription Drug Misuse				Support of sig. other -.12	Depressive Symp. .10
Prevalence	Benchmark			Perc. family coping -.09	Financial stress .09
1.20%	.30%			Spouse coping -.10	
				Marital satisfaction -.13	
Suicidality		Community safety -.16	leadership sup. -.11	Perc. family coping -.12	Depressive Symp. .26
Prevalence	Benchmark		group cohesion -.10	parenting satisfaction -.15	Perc. personal coping -.20
5.60%	8.2%				Financial stress .10

Worksheet 1

Directions: Use the Feedback Report to retrieve information and values.

1. *First column*: Use the bar charts to indicate prevalence and benchmark values.
2. *Other columns*: Use the tables to indicate risk and protective factors. See the list on pages 3-4 to place factors into their correct columns: Community, Organizational, Family, or Individual. Remember to include the *r* number that indicates strengths of relationships.

Target Problem Prevalence/ Benchmark		**Risk and Protective Factors/ Strength of Association**							
		Community		**Organization**		**Family**		**Individual**	
Spouse Physical Abuse		♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂
Prevalence	Benchmark								
♂→♀ ♀→♂									
Spouse Emotional Abuse		♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂	♂→♀	♀→♂
Prevalence	Benchmark								
♂→♀ ♀→♂	No Benchmark								
Child Physical Abuse									
Prevalence									
Child Emotional Abuse									
Prevalence	Benchmark								
	No Benchmark								

Target Problem Prevalence/ Benchmark		**Risk Factors/ Strength of Association**			
		Community	**Organization**	**Family**	**Individual**
Child Neglect					
Prevalence	Benchmark				
	No Benchmark				
Alcohol					
Prevalence	Benchmark				
Street Drug Use					
Prevalence	Benchmark				
Prescription Drug Misuse					
Prevalence	Benchmark				
Suicidality					
Prevalence	Benchmark				

II. Worksheet 2: Short List of Factors and Programs

A. Short List of Factors by Strength and Frequency

On Worksheet 1, review the factors and their associations for two features:

- which have the stronger association values, and
- which may be associated with more than one problem and appear frequently throughout the table.
- (It may be helpful to mark or highlight them while scanning.)

Next, examine the first column of Worksheet 1 for the percentages of the base population associated with those factors. Prioritize the factors that affect either a large portion of the population, or that are relevant for an entire base community over a small subgroup.

List them list them in the first column in roughly descending order of priority.

See the sample of Worksheet 2 (next page). The risk factor known as Depressive Symptomatology was prioritized because of its relatively high values and its frequent representation on sample Worksheet 1.

B. List Target Problems

Complete the second column of Worksheet 2 by listing all the associated target problems for each chosen factor. Also indicate the strength of relationship values.

See the sample of Worksheet 2 (next page). All of the target problems associated with Depressive Symptomatology, indicated on Worksheet 1, were Suicidality (.25), Alcohol (.11), Prescription Drug Misuse (.10), Child Emotional Abuse (.09), and Child Physical Abuse (.05).

C. Rate Existing Programming

Which factors are the most changeable? Which already have current programming in place to address them?

Use an informal rating system that is meaningful to IDS members (e.g. numeric scale, or descriptive labels such as *difficult*, *neutral*, and *easy*) to rate the difficulty of addressing each factor. Consider money, human resources, and base infrastructure.

III. Worksheet 3: Discussion Guide

Worksheet 3 serves as an organizing tool to structure planning discussions among IDS members.

Worksheet 2 — *sample*
Short List of Factors and Programs

Directions: Use information from Worksheet 1 to complete. See Training Manual Section 3 for more detail.

1. Scan factors by strength (the closer to -1 or +1 , the stronger the relationship) and frequency in table.
2. *First column*: List risk and protective factors from roughly higher to lower priority.
3. *Middle column*: List all the associated problems for each factor.
4. *Last column*: Rate existing programming.
5. Select one or two factors to target.

Risk Factor	Target Problems	Current Programming
Depressive Symptomatology	Suicidality .26	
	Spouse emotional abuse .24 & .08	
	Alcohol .11	
	Prescription Drug Misuse .10	
	Child Emotional abuse .09 Child physical abuse .05	
Perceived Personal Coping	Suicidality -.20	
	Spouse emotional abuse -.20 and -.08	
	Child emotional abuse .-12	
	Spouse physical abuse -.11	
	Child neglect -.05 Child physical abuse -.04	
Support of Significant Other Financial Stress	Spouse physical abuse -.17 and -.11	
	Spouse emotional abuse -.13	
	Prescription Drug abuse -.12	
	Spouse physical abuse .16 and .11	
	Suicidality .10	
Community Safety	Prescription drug abuse .10	
	Child physical abuse .04	
	Suicidality -.15	
	Prescription drug abuse -.12	
	Alcohol abuse -.08	
Family Coping	Spouse physical abuse -.15	
	Suicidality -.13	
	Spouse emotional -13 and -.05	
	Prescription drug abuse -.09	
	Child emotional -.11 Child physical -.08 Child neglect -.06	

Worksheet 2:
Short List of Factors and Programs

Directions: Use information from Worksheet 1 to complete. See Training Manual Section 3 for more detail.

1. Scan factors by strength (the closer to -1 or +1 , the stronger the relationship) and frequency in table.
2. *First column*: List risk and protective factors from roughly higher to lower priority.
3. *Middle column*: List all the associated problems for each factor.
4. *Last column*: Rate existing programming.
5. Select one or two factors to target.

Risk Factor	Target Problems	Current Programming

Worksheet 3:
Discussion Guide

Directions:

1. Examine Worksheets 1 and 2.
2. As a team, discuss what the data suggest are the priorities.
3. List Top Target Problems and Top Factor Associations based on discussion.

Top Target Problems

1. _____
2. _____
3. _____

Top Risk/Protective Factor Associations

1. _____
2. _____
3. _____

What do these two lists have in common?

_____

1. What are the potentially strong risk/ protective factors?
2. Which risk and protective factors relate to the most problems?
3. Are there any other problems that should be of high priority?
4. What are the priorities for leadership?
5. What programs are currently in place to address the priorities?

Section 4 — Guidebook

I. NORTH STAR's Fit with Existing Activities

NORTH STAR programs are intended to supplement rather than supplant programs that already exist to address base problems. A program begun under NORTH STAR might serve as an addition, a replacement, or an enhancement that simply broadens the impact of another program outcome.

Plan to add activities from the Guidebook to base efforts when they complement existing programs in their entirety and not necessarily as stand-alones. Replace existing programs completely where current interventions have failed to show beneficial impact on community functioning. Finally, remember that some activities in the Guidebook might overlap with existing efforts. By simply incorporating additional (missing) elements and omitting others, it might be possible to improve the efficacy of an existing effort with few or no additional resources.

Current activities that are already succeeding may continue to be prioritized as highly as those begun as part of NORTH STAR.

II. Selecting Appropriate Activities

The Guidebook is organized by Community, Organizational, Family, and Individual Problem sections. Activities are listed under subject headings from the CA such as Parent-Child Relationships and Perceived Family Coping Ability.

A variable listed in one section may impact risk/protective factors in other areas. For example, an activity might show improvement in community well-being even if the target is an individual one such as personal coping. The general procedure for selecting activities is this:

- Decide what factors to target. (See Worksheets, Section 3.)
- Use the Guidebook to find the most appropriate chapter.
- Review the activities that address your chosen factors and consider how the activities might mesh with your base priorities, budget, and work load.
  - — Does base infrastructure already exist to implement this program?
  - — Are there agencies ready to take on the activities needed for minimum implementation of the chosen activity?
  - — Will the activities be compatible with the base and base community's mission, culture, and preferences?
  - — What other matters of resources, labor, and marketability are there to consider?

A. Guide Sheet 1: Choose the Right Activity

Complete Guide Sheet 1 to summarize which activities could best serve base needs. Compare activities (perhaps using a numeric scale) by considering risk and protective factors, predictable impact, overall cost benefit, and existing community infrastructure.

It may be necessary to gather some program specific information on which to base your choices. The NORTH STAR guidebook contains contact numbers/addresses for obtaining more information about a program.

B. Guide Sheet 2: Activity Implementation

Use Guide Sheet 2 to help organize your IDS' discussions about choosing activities to implement and planning their implementation.

Guide Sheet 1: Choose the Right Activities

Directions: Use the Guidebook to complete the grid.

	Potential Activity 1	**Potential Activity 2**	**Potential Activity 3**	**Potential Activity 4**
Target Audience				
Personnel hours required for implementation				
Marketability				
Intensity				
Feasibility				
Resource Allocation				
Potential Benefits				
Overall Cost Benefit				

Guide Sheet 2: Activity Implementation

Directions:
1. Complete the form to begin planning activity implementation.
2. Complete one sheet for each activity you selected.

Activity Name: _____

1. What are the risk and protective factors addressed by this activity?

_____

_____

_____

_____

2. What are the goals and objectives of the activity?

_____

_____

3. What are the arguments for and against this particular activity?

Pros	**Cons**

4. What constitutes minimum implementation for this activity? (Are there modules that can be omitted without its losing effectiveness?)

5. What are the resources required to achieve minimal implementation?

6. Who is the target population?

7. Are adaptations required for our target population? What are they?

8. What agencies will be involved and collaborate?

9. Which agency will do what?

Agency	Task

C. Guide Sheet 3: Action Plan

Completing an action plan represents a proactive approach to problem solving. It is also a key element to capacity building.

The first steps in planning are to define the mission by identifying the audience and narrowing the focus. This ensures that the correct audience is targeted.

Next, further narrow the focus by setting specific goals — what and who you want to target. Narrow your focus by setting specific goals. Choose risk factors to target and activities to address those factors. The big goal is to have those risk factors come out differently on the next community assessment. In the meantime, we need a way of measuring how we are doing with the current planning. Short term goals should be defined according to your activity choice.

Establish objectives to map out the more detailed planning it takes to establish a new program. There should be an objective for every activity that is part of your program. There should be a plan for measuring the objectives you choose as well.

Specifically plan what you are going to do and who is going to do it when. It's important for agencies to be clear on their role and what they need to accomplish to do their part as well as when their tasks are 'due'. It helps to make sure everything is in writing and a record is kept of what will be done, who will do it, and when it will be done.

Part of the plan should be a measure of outcomes. Once the goals are defined, there should be a way of measuring if they have been adequately met or not. How we attain those goals matters as well. Is the process of implementing and sustaining the program working? Can it be maintained? While we expect growing pains and some difficulty getting started, activities that you have to continually grit your teeth to implement are not sustainable and not viable long-term.

Part of the plan should also include scheduled briefings to keep leadership, participants, and involved agencies up to date on the project status.

Guide Sheet 3: Action Plan — *sample*

Community Result – 1

Target Problem:

Parents will have an increased sense of competence and prevent child behavioral problems by increasing their parenting skills. Marital satisfaction will also increase.

Target Factor(s):

parenting satisfaction, relationship satisfaction

Evaluation plans:

- a pre- and post-test of selected parents evaluating their parenting competencies.
- a look at cases of families seeking services to see if case load has increased, decreased, or remained constant.

Target Group:

all active duty parents and spouses

Rationale:

The community assessment has shown a high level of child neglect. Our CA feedback reports indicate that parenting satisfaction and relationship satisfaction are risk factors related to child neglect. We are going to address those risk factors directly to support parents and drive down our rate of child neglect.

Program Result – 1

Include information on evaluation plan

The IDS will initiate the Triple P program. The media component will be evaluated using a survey randomly administered in the commissary to measure awareness. The parental primary care session will be evaluated by a pre- and post-test.

Target Group:

all active duty parents and spouses.

Rationale:

Triple P is a program with proven results showing lower levels of child behavior problems and positive impact on marital satisfaction.

Program activity – 1a

Include information on evaluation plan

- media campaign using flyers in the commissary and BX
- posters in doctors' offices and child care facilities
- random survey on weekend of commissary shoppers

Program activity – 1b

Include information on evaluation plan

A parenting education program is planned on 3 dates. Participants will be given before and after assessments to measure what was learned.

Guide Sheet 3: Action Plan

Community Result – 1
Target Problem:

Target Factor(s):

Evaluation plans:

Target Group:

Rationale:

Program Result – 1
Include information on evaluation plan

Target Group:

Rationale:

Program activity – 1a
Include information on evaluation plan

Program activity – 1b
Include information on evaluation plan

III. Fidelity and Adaptation

A. What is fidelity?

Fidelity is the extent to which a program implementation matches the way in which the developer designed the program to function successfully. When a program is followed precisely to the letter, it is said to have been carried out with 100% fidelity.

Unfortunately, many programs are not implemented with 100% fidelity. Low fidelity makes obtaining favorable results more difficult. Examine programs carefully to determine minimum implementation requirements.

B. What is adaptation?

Adaptation is how a program or activity is fine-tuned to suit a target population. As one might expect, one size does not always fit all. Adaptation requires careful adjustment of a program to fit specific goals and a target population without eroding the effectiveness of that program.

C. Finding a Balance

One of the great challenges of using a science-based approach to programming is achieving a balance between maintaining fidelity to a program's proven design while adapting that program to meet the needs of a specific population and set of goals. Some activities generalize easily to a range of populations and situations. Others are so rigidly designed that the adjustment of one small component would mean a compromise in outcomes.

In some cases, documentation exists to show that a program is effective in its entirety and can produce measurable outcomes, but the specific effectiveness of isolated program components may not be substantiated. Therefore, the burden is on the implementers to examine choices carefully and weigh the needs of the community against the program requirements. In the long run, time devoted to very careful planning and activity selection is time well invested.

To find a balance with each program, define the core components to that program or activity. Some activities in the Guidebook have few implementation guidelines and clearly indicate which parts of their parts are crucial to successful outcome. Others have not been evaluated for even minimal implementation. So it is up to the practitioner to read through the material and use the best judgment about what might be implemented and what can be omitted.

Finally, when assessing a program's utility, it can be beneficial to enlist the opinions of collaborating agency personnel. There may be a valid concern about particular components being skipped or a recommendation that an adjustment is needed. Collaborating to review a program can build consensus, foster cooperation, and help in avoiding misunderstandings and unrealistic expectations in the future. Part of such a review should also involve identifying critical resources and ensuring that all parties understand who will provide them.

D. Guide Sheet 4: Fidelity and Adaptation of Programs

Monitoring fidelity requires keeping close watch on program implementation. As procedures are examined and continuously customized, the process should be documented. This establishes a record of the components that were successful and should be maintained, what succeeded after some customizing and adapting, and what did not work as well as it might have.

Guide Sheet 4 provides space for such ongoing monitoring.

Guide Sheet 4: Program Fidelity and Adaptation

1. List the program core components.

2. List the 'optional' components.

3. List adaptation concerns (from all collaborating agencies).

Section 5 — Evaluation

What is program evaluation?

Program evaluation is about continuous progress. At some point, even the most perfectly planned and implemented activity needs to be changed, adapted, or improved. The fact that such changes will intermittently be required does not signify failure. Rather, it indicates that there will be positive growth, and since everything can be improved upon in some way, the potential for growth and improvement is limitless.

Evaluation can be cost saving as well. When outcomes indicate a serious shortcoming with a particular activity, the data can justify discontinuing it and transferring precious resources toward another effort.

Program evaluation is:

- about improvement and growth.
- not about proving the success or failure of a program.
- a flexible process.
- not complex.

A. Process Evaluation

Process evaluation examines the procedural implementation of an activity.

Designing a process evaluation involves asking questions such as:

- What do we need to do to implement the program?
- How do we need to implement each component?
- What is required of participants?
- What is required of the staff for implementation?
- What is the general process participants go through during the program?
- What do staff, practitioners and participants consider the strengths of the program?

Process evaluation is highly specific to the activity you are evaluating. The focus stays on how an intervention is implemented and how it operates. It emphasizes procedures and details of implementation to address whether the intervention is delivering the intended services.

B. Outcome Evaluation

Outcome evaluation, on the other hand, measures whether a program had an effect. It verifies if the correct strategy was chosen to accomplish a target goal. An outcome evaluation for NORTH STAR would require a measurement of the results that the selected activity was intended to alter.

Outcome evaluation is synonymous with "Results Management" activities contained the *Building Community Capacity* Manual.

Measurements made as part of an outcome-based evaluation of a chosen activity are the "intermediate outcomes" mentioned in the Results Management chapter in the Community Capacity Building Manual.

- Identify the major outcomes you expect to see from your program.
- Choose the outcomes you think you can easily measure.
- Specify the measures you will use for your chosen outcomes.
- Specify target goals for your outcomes. (For example, you may want to lower the number of DWI incidents in your community by 50%.)
- Plan how you will measure your target goals, what information to gather, and how to gather it. Consider what information will and will not be available due to privacy issues.

C. Planning evaluations

How to Plan an Evaluation

- What do you want to know?
  - Process
  - Outcomes
- What will you do with this information?
  - Schedule briefings
  - Participant feedback
  - Program improvement
  - Plan ahead
- How are you going to find out?
  - Survey
  - Interview
  - Focus group
  - Observation
  - Document analysis
- When are you going to find out? (Do you want to know if the intervention is going to have lasting effects? Or are you more interested in the immediate impact?)
  - During the program? When?
  - Immediately after the program? When?

When? A specified period of time after the program?

D. Common Methods of Evaluation

Method	Purpose	Pros	Cons
Survey	Gather information from individuals.	• Complete anonymously • Inexpensive • Many individuals • Lots of data • Easy to develop	• People lie • Sampling difficult • Doesn't cover the full story
Interviews	Gathering richer or more complete information.	• Full range and depth of information • Adapt follow up questions to respondent's answers	• Time consuming • Hard to analyze • Potential bias
Documentation Review	Present a picture in time of a program without interruption.	• Comprehensive information • Information is already there • Few biases	• Time consuming • Information can be incomplete • Inflexible
Observation	Gather accurate process information.	• Real time glimpse into operations • Provides feedback for adaptation	• Can be difficult to interpret • Can interrupt participants
Focus Groups	Explore topic in depth through group discussion.	• Reliable common impressions for participants and practitioners	• Qualitative responses can be difficult and time consuming • Need for experience facilitator • Difficult to schedule participants together
Case Study	Fully understand one participant's experience in a program.	• Intense method of portraying program to outsider • Presents a full picture of the complete experience	• Typical participant is difficult to find • Very time consuming • May not present an accurate overall picture

Evaluation Sheet 1:
Monitoring an Implementation

1. Did participants learn what we wanted them to learn?

2. Did we reach the number of people we wanted to reach? If not, how can we improve our numbers?

3. Did people enjoy/appreciate the program? Do they want it to continue?

4. Did participants dislike the program? What, specifically, did they dislike?

5. What were the strengths and weaknesses of how we implemented the program?

6. Can we decrease the time it takes to carry out the activity? How?

7. Can we decrease the cost of the program? How?

Evaluation Sheet 2:
Process Evaluation

Directions:

1. Select the questions determined to be the most helpful in your process evaluation. Disregard the rest.

1. What do we need to do to implement the program?

   — How can each of these tasks be rated, measured, or improved?

2. How do we need to implement each component?

   — How can each of these tasks be rated, measured, or improved?

3. What is required of participants?

   — How can participant involvement be rated, measured, or improved?

4. What is required of staff implementing the program?

   — How can staff tasks be rated, measured, or improved?

5. What is the general process participants go through during the program?

   — How can this process be rated, measured, or improved?

6. What do staff, practitioners, and participants consider the strengths of the program?

7. What do staff, practitioners, and participants consider the weaknesses of the program?

8. How much contact was there with participants?

   — Number of: phone calls? Personal contact? Group sessions?

9. Are the resources dedicated to the program adequate? Can they be improved?

10. Is the program convenient/ available to the target population?

11. Did participants attend the number of sessions the program required?

12. Did mass media promotions reach their target audience?

13. Did participants do the program? (read the book, watch the video, etc.)

14. Did the participants learn what they were supposed to learn?

15. Are the facilities where the program is offered adequate?

Evaluation Sheet 3 — *sample*
Outcome Evaluation

Directions: Complete the following for each activity to help plan ahead.

1. What is the expected outcome of your chosen program?
We expect to improve parenting satisfaction and marital satisfaction on base.

2. How will the outcome be measured?
It will be measured in the 2005 CA.

3. What are the expected outcomes of each activity?
We will initiate a media campaign on parenting by using recommended posters for the triple P program. Parenting programs will be offered by family member programs.

Who will do what? Capt. Morris will develop flyers. Sgt. Lane will distribute.
When will they do it? May 2004
How will they do it? Flyers will be done using MS publisher. FAP will provide materials.
What resources will be required? Paper, software (already have), ¼ day to distribute flyers.

How will outcomes be communicated to leadership personnel?
Quarterly CAIB meetings

How will outcomes be communicated to participants (if applicable)?
Newsletter will go to participants in the parenting programs. Posters in BX will also disseminate progress.

Who will be briefed on progress of the program?
CAIB, first shirts.

Evaluation Sheet 3:
Outcome Evaluation

Directions: Complete the following for each activity to help plan ahead.

1. What is the expected outcome of your chosen program?

2. How will the outcome be measured?

3. What are the expected outcomes of each activity?

   Who will do what?

   When will they do it?

   How will they do it?

   What resources will be required?

4. How will outcomes be communicated to leadership personnel?

5. How will outcomes be communicated to participants (if applicable)?

6. Who will be briefed on progress of the program?

D. Sustainability

Sustainability involves the capacity for a community to continue an activity. During an initial period, it may be feasible to devote some extra time, personnel, effort, and commitment to a program until it becomes established. However, if the costs of applying such measures outweigh the benefits, then it is unlikely that the program will be sustained.

Examples of some pitfalls to avoid:

Agency capacity — An agency may start a program in what is normally a slow season and feel confident that things are going well, but when conditions return to normal, it may lack the resources to continue the activity.

Individual capacity — A person with strong leadership skills may carry a program through implementation and initial evaluation. However, if that individual PCSs, the procedures may not be in place for the work to continue with new personnel.

Community capacity — Can the community sustain the program? Are the resources available? Or, does the community still need the program? If another initiative comes along that can fulfill some of the same needs, it may become necessary to select just one program.

Notes: